

Medicaid MAGI Eligibility & Benefits State Plan Amendments

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

AFDC Income Standards

S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	188	X
+	2	262	X
+	3	351	X
+	4	413	X
+	5	509	X
+	6	581	X
+	7	652	X

Additional incremental amount

Yes No

Increment amount \$

The dollar amounts increase automatically each year

Yes No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a



Medicaid Eligibility

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the statewide standard

	Household size	Standard (\$)	
+	1	201	X
+	2	270	X
+	3	338	X
+	4	407	X
+	5	475	X
+	6	544	X
+	7	612	X

Additional incremental amount

- Yes No

Increment amount \$

The dollar amounts increase automatically each year

- Yes No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

AFDC Need Standard in Effect As of July 16, 1996



Medicaid Eligibility

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

- Yes No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way



Medicaid Eligibility

The dollar amounts increase automatically each year

Yes No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

Yes No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option

S13a

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

The dollar amounts increase automatically each year

Yes No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Parents and Other Caretaker Relatives

S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

- Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

- Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

Options relating to the definition of caretaker relative (select any that apply):

- The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

Unmarried partner whether of the same or different gender

- The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

- The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Options relating to the definition of dependent child (select the one that applies):

- The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

- The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):



Medicaid Eligibility

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:



Medicaid Eligibility

- A percentage of the federal poverty level: %
- The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.
- Other dollar amount

Income standard chosen:

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard

The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

Another income standard in-between the minimum and maximum standards allowed

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

Pregnant Women - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

Yes No

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for this group

Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for this eligibility group is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - 185% FPL

The amount of the maximum income standard is: % FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

- The minimum income standard
- The maximum income standard
- Another income standard in-between the minimum and maximum standards allowed.

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

- All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

- Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Infants and Children under Age 19

S30

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

Infants and Children under Age 19 - Infants and children under age 19 with household income at or below standards established by the state based on age group.

The state attests that it operates this eligibility group in accordance with the following provisions:

Children qualifying under this eligibility group must meet the following criteria:

Are under age 19

Have household income at or below the standard established by the state.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

Income standard used for infants under age one

Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

Yes No

The minimum income standard for infants under age one is 133% FPL.

Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
 - The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
 - 185% FPL

Enter the amount of the maximum income standard: % FPL

Income standard chosen

The state's income standard used for infants under age one is:

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age one through age five, inclusive

Minimum income standard



Medicaid Eligibility

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: % FPL

Income standard chosen

The state's income standard used for children age one through five is:

- The maximum income standard
- If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
- 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
- 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.



Medicaid Eligibility

- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age six through age eighteen, inclusive

Minimum income standard

The minimum income standard used for this age group is 133% FPL.

Maximum income standard

- The state certifies that it has submitted and received approval for its converted income standard(s) for children age
- six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- 133% FPL

Income standard chosen

The state's income standard used for children age six through eighteen is:



Medicaid Eligibility

The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

There is no resource test for this eligibility group.

Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage

S32

Adult Group

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes No

Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is

receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

PRA Disclosure Statement



Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Former Foster Care Children

S33

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

- Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

The state attests that it operates this eligibility group under the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Are under age 26.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

Yes No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. <input type="radio"/> Yes <input checked="" type="radio"/> No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage	S51
Optional Coverage of Parents and Other Caretaker Relatives	

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage

Reasonable Classification of Individuals under Age 21

S52

42 CFR 435.222

1902(a)(10)(A)(ii)(I)

1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Children with Non IV-E Adoption Assistance S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

Yes No

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

Are under the following age (see the Guidance for restrictions on the selection of an age):

Under age 21

Under age 20

Under age 19

Under age 18

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

Yes No

Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Yes No

Income standard used for this eligibility group

Minimum income standard

The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Optional Targeted Low Income Children

S54

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage

Individuals with Tuberculosis

S55

1902(a)(10)(A)(ii)(XII)

1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

Yes No

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Independent Foster Care Adolescents

S57

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals Eligible for Family Planning Services

S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

Yes No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes No



Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax Machine	application accepted by facsimile transmission	X
+	Email	application accepted by email attachment	X

- The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:
- Once every 12 months
 - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional
- information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.
- Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):
- Once every 12 months
 - Once every 6 months
 - Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

- The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between
- Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

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USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

Paper Application Online Application

TRANSMITTAL NUMBER:

DE 13-0006-MM

STATE:

Delaware

Through October 31, 2014, the state is using an interim alternative single streamlined application. After October 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATIONS

Paper Applications Online Application

TRANSMITTAL NUMBER:

DE 13-0006-MM

STATE:

Delaware

Through March 1, 2014, the state is using interim alternative single streamlined paper applications for individuals and families and an interim paper application used to apply for multiple human service programs. After March 1, 2014, the state will use revised alternative single streamlined paper applications. The revised applications will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's applications. The revised applications will be incorporated by reference into the state plan.



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)

APPLICATION FOR FOOD BENEFITS, CASH,
MEDICAL, AND CHILD CARE ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)



Apply faster online

Apply faster online at www.assist.dhss.delaware.gov

This includes anyone wishing to apply for Medical Assistance only.



Who can use this application?

- Use this application to apply for anyone in your home including any tax dependents who are out of the home.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- If applying for Medical Assistance only, you may be able to use a short form.



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants)
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family. You may need to complete Appendix A.



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**



What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps. If you don't hear from us, call 1-800-372-2022.



Get help with this application

- **Phone:** Call our Customer Relations Unit at **1-800-372-2022.**
- **In person:** There may be social workers/case managers in your area who can help.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-866-843-7212.**
- **In a language other than English:** Call **1-866-843-7212.**
- **TTY users:** Call **711** or **1-800-232-5460.**



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
 APPLICATION FOR FOOD BENEFITS, CASH,
 MEDICAL, AND CHILD CARE ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing food benefits, medical, child care, and cash assistance. We can provide information about other helpful services in your community. You can answer only the questions related to the program(s) you are applying for. If you answer ALL the questions on the Assistance Application, we can see if you are eligible for all programs. A friend or relative, or anyone that you wish, may help you complete this application.

Your application is not complete until you sign the last page. Return the application to us.

At your interview, you will need to show us:

- Proof of who you are
- Proof of your address
- Proof of child care costs (only for cash assistance)
- Proof of money you have received in the last 30 days

STEP 1 Tell us about yourself.

(We need one adult in the household to be the contact person for your application.)

For which program(s) are you applying?

- Cash Assistance Food Benefits
 Medical Assistance Child Care

First Name, Middle Name, Last Name, & Suffix		
Home Address		
City	State	Zip Code
Mailing Address (if different from Home Address)		
City	State	Zip Code
Primary Telephone	Secondary Telephone	
Preferred Methods of Contact		
I want to receive information about this application and future communication by: <input type="checkbox"/> Email Address <input type="checkbox"/> U.S. Mail		
E-Mail Address: _____		
Preferred spoken or written language (if not English)		

If you wish to have someone else manage your case and act as your representative, please complete Appendix C. For Food Benefits, the day we get this first page of the application with your name, address, and signature sets the date benefits may start if you sign and return the completed application to DHSS within 30 days.



 Applicant's Signature (Required)

 Date

 Authorized Representative's Signature

 Date



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
 APPLICATION FOR FOOD BENEFITS, CASH,
 MEDICAL, AND CHILD CARE ASSISTANCE

Delaware's Emergency Food Benefit

If your household has little or no income right now, you may be able to receive emergency food benefits within 7 days from the day we receive your completed application.

You may be able to get emergency food benefits in seven days if:

- Your household expects to receive less than \$150 in income this month
- Your household does not have more than \$100 in cash or bank accounts
- Your household is a migrant or seasonal farm worker household
- Your household's rent, mortgage, and utilities are more than your household's gross monthly income and liquid resources combined



Delaware's Food First Electronic Benefits Transfer (EBT) Card



We issue food benefits on an EBT card. To use your food benefits, you must have an EBT card and a Personal Identification Number (PIN). When we approve your benefits, our EBT vendor will mail your card to you if you never had one before. You can also go to a card issuance site to get your card.

In each of the headings in this application, you will see program symbols. These symbols will help you to identify the questions you must answer for the program(s) you are requesting.

Symbols	Programs	Terms	Definition
	Medical Assistance Programs (doctors, hospitals, prescriptions, labs, and x-rays) - free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP) - affordable, private health insurance plans through the Marketplace - a new tax credit that can immediately help pay your premiums for health coverage	Alien:	A person who is not a U.S. citizen
	Child Care Assistance (help with the cost of child care)	EBT card:	Electronic Benefit Transfer—a plastic card that you use at a store to buy food.
	Cash Assistance - Temporary Assistance for Needy Families (TANF) - General Assistance (GA) - Refugee Cash Assistance (RCA)	Eligible:	Meeting all of the guidelines to get benefits.
	Food Supplement Program (help with monthly food expenses)	Household:	A person or a group of people who live together and buy food and fix meals together.
	Signature Required	ABAWD:	Able Bodied Adult Without Dependents—An adult aged 18 through 50 years old, without dependents, and physically able to work.

STEP 2

Tell us about yourself and the people in your household.

Are you? Single Married Divorced Civil Union Separated Widowed Unmarried Partnership

Instructions

Fill in the blocks for all of the people who live with you. If you are applying for medical assistance and file taxes, we need to know about everyone on your tax return.

Race: B = Black/African American W=White Ethnic Group: H=Hispanic/Latino
 PI = Native Hawaiian/Pacific Islander A=Asian N=Non-Hispanic/Latino
 I = American Indian/Alaskan Native (If anyone in your household is American Indian/Alaskan Native, also complete Appendix B.)

Last Name	First Name, Middle Name	Relation to you	Are you applying for this person?	Sex M/F	Birth Date mm/dd/yyyy	Social Security Number*	Race/Ethnic Group (optional)	U.S. Citizen? Answer for applicants only. **
		Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No

*We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov.

TTY users should call 1-800-325-0778.

**Applies to applicants for health coverage only.

Complete this section for legal alien applicants only.

1. Do applicants have eligible immigration status? Yes. Complete the section below.

Name	Immigration Document Type	Document ID number	Have you lived in the U.S. since 1996?	Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

2. Has anyone ever received cash, food, or child care assistance in another state? Yes No

What benefits? _____ Name of state? _____ Month/Year _____

3. Has anyone ever been disqualified for cash or food assistance in another state? Yes No

What benefits? _____ Name of state? _____ Month/Year _____

4. Is anyone in your household in violation of probation or parole or fleeing prosecution? Yes No
(Applies to TANF, food benefits, and general assistance.)
5. Has anyone been convicted of a drug felony after August 22, 1996? Yes No
(Applies to TANF and general assistance.)
6. Have you or any member of your household been convicted of trading food benefits for drugs after September 22, 1996? Yes No
(Applies to food benefits.)
7. Have you or any member of your household been convicted of buying or selling food benefits over \$500 after September 22, 1996? Yes No
(Applies to food benefits.)
8. Have you or any member of your household been convicted of fraudulently receiving duplicate food benefits in any state after September 22, 1996? Yes No
(Applies to food benefits.)
9. Have you or any member of your household been convicted of trading food benefits for guns, ammunitions, or explosives after September 22, 1996? Yes No
(Applies to food benefits.)
10. Answer the questions below if a parent(s) of any child under 18 does not live in your household.

Child's Name	Absent Parent's Name	Absent Parent's Date of Birth	Absent Parent's Social Security Number	Absent Parent's Address	Absent Parent's Employer

11. Are there any children under the age 19 living in the household? Yes No If yes, fill in below.

Parent or Caregiver's Name	Child's Name

STEP 3 Tell us about your health care.



Is anyone in your household offered health coverage from a job (even if the coverage is from someone else's job, such as a parent or spouse)? If yes, you'll need to complete Appendix A. Yes No

Is this a state employee benefit plan? Yes No

Other than Medicaid does anyone in your household have health insurance or Medicare? Yes No

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor • Hospital • Lab Tests • X-rays	
			Doctor • Hospital • Lab Tests • X-rays	
			Doctor • Hospital • Lab Tests • X-rays	

12. Name anyone in your household who is pregnant _____ due date _____
How many babies are expected during this pregnancy? _____
13. Name anyone who has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home _____
14. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.). _____

15. Does anyone plan to file a tax return for current year? Yes No
 (You can still apply for medical assistance even if you don't file a tax return.)
 If yes, please fill in below and answer question A. If no, skip to question B.

Name of Tax Filer	Who will be claimed as a Tax Dependent

A. Will anyone file jointly with a spouse? Yes No

If yes, name of spouse: _____

B. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, please list the name of the tax filer and how you are related to the tax filer: _____

16. Do you want help paying for medical bills from the last 3 months? Yes No

17. Name anyone in your household who was in Delaware Foster Care at age 18 or older and received Delaware Medicaid Benefits: _____

STEP 4 Tell us about the money people in your household get.



Employed

If anyone is currently employed, tell us about his or her income. Start with question 18.

Not employed
Skip to question 30.

Self-employed
Skip to question 28.

CURRENT JOB 1

18. Please list the person's name: _____

19. Employer name and address _____

20. Employer phone number

() - _____

21. Wages/tips/commission (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
\$ _____

22. Average hours worked each WEEK _____

CURRENT JOB 2

23. Please list the person's name: _____

(If your household has more jobs, attach another sheet of paper.)

24. Employer name and address _____

25. Employer phone number

() - _____

26. Wages/tips/commission (before taxes) Hourly Weekly Every 2 weeks Twice a month Monthly Yearly
\$ _____

27. Average hours worked each WEEK _____

SELF-EMPLOYMENT

28. Please list the person's name: _____

29. If self-employed, answer the following questions:

a. Type of Work _____

b. How much gross income will you get from this self-employment this month?
\$ _____

c. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
\$ _____

30.

<input type="checkbox"/> OTHER INCOME			
Where does the money come from?	Who gets the money?	How much do they get?	How often are they paid?
Social Security		\$	
Supplemental Security Income (SSI)		\$	
VA Benefits		\$	
Pensions		\$	
Retirement Accounts		\$	
Unemployment Compensation		\$	
Workers Compensation		\$	
Child Support		\$	
Alimony Received		\$	
Work Study		\$	
Money Earned from Interest or Dividends		\$	
Net Farming/Fishing		\$	
Net Rental/Royalty		\$	
Other Income		\$	

CHANGE IN EMPLOYMENT

31. In the past year, did anyone: Change jobs Stop working Start working fewer hours None of these



Complete questions 32 - 34 for Food Benefits Only

32. Has anyone in your household quit a job in the last 30 days? Yes No
 If yes, employer name _____
33. Is anyone in your household a migrant or seasonal worker? Yes No
 If yes, who? _____
34. Is anyone in your household on strike? Yes No
 If yes, who? _____

STEP 5 Which of the following do you have?



Complete this section for Cash Assistance Only

35. Does anyone in your household have any vehicles (don't include your car)?
 Yes No If yes, provide the following information:

Make	Model	Year	Amount Still Owed
			\$
			\$

36. Does anyone have or own any land, buildings, or houses other than the one you live in? Yes No

If yes, who owns it? _____

37. Does anyone receive income from these properties? Yes No

If yes, how much? \$ _____

38. Does anyone in your household have any of the following?

Type of Account	Yes or No	Name on the account	Account Number	Balance
Bank or Credit Union	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
Stocks or Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
Savings Certificates	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
IRAs or Keogh	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
Trust Funds	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
Cash On Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$

STEP 6 Tell us about your tax deductions.



Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29c).

- Alimony paid \$ _____ How often? _____
- Student loan interest \$ _____ How often? _____ Type: _____
- Other tax deductions* \$ _____ How often? _____

*For other potential deductions, refer to your current tax return form 1040 under the Adjusted Gross Income section.

STEP 7 Tell us about your medical expenses.



If you or anyone in your household has medical expenses and are age 60 or older, or blind, and/or receiving Federal disability benefits (SSA, SSI, VA), please list the name of the person and the amount of the medical expenses paid monthly.

Name		Name	
Hospitalization	\$	Hospitalization	\$
Prescription drugs	\$	Prescription drugs	\$
Doctor	\$	Doctor	\$
Eye Care	\$	Eye Care	\$
Dental	\$	Dental	\$
Insurance Premiums	\$	Insurance Premiums	\$
Transportation for medical care	\$	Transportation for medical care	\$
Other	\$	Other	\$

STEP 8

Tell us about your household expenses.



Please tell us about your bills. (Copies of bills may be needed.)

Shelter:

What are your shelter expenses (enter what you are required to pay)?

39. Rent: \$ _____ per month
Is this Section 8, HUD or other rental assistance? Yes No
Does your rent include meals (room and board)? Yes \$ _____ No
Or are you paying for meals only? Yes \$ _____ No
40. Mobile Home Lot Rent \$ _____ per month
41. Mortgage/ Mobile Home \$ _____ per month
42. Second Mortgage or Home Equity Loan \$ _____ per month
43. Homeowner's Insurance \$ _____ per month
44. Property Taxes \$ _____ per month
45. Special Assessment \$ _____ per month
46. Condominium/Association Fees \$ _____ per month

Utilities:

Check the boxes that apply and fill in the amount.

- Electric \$ _____
- Air Conditioning (central or window unit) \$ _____
- Heat (gas, electric, oil, propane, wood, kerosene) \$ _____
- Gas (cooking) \$ _____
- Water/Sewer \$ _____
- Trash \$ _____
- Telephone \$ _____
- HUD/WHA/DSHA (utility allowance check) \$ _____
- Excess Utilities Only \$ _____

Other:

47. Dependent Care Expenses? Yes \$ _____ No
48. Legally-obligated Child Support Payments? Yes \$ _____ No

Reporting and Verifying Expenses:

Please be sure to enter all of your expenses so that you can qualify for the full amount of food benefits that you need. If you do not put an expense down, we will not be able to count it as we decide the amount of aid to give you.

- Shelter (rent/mortgage/lot) expenses;
- Real estate taxes;
- Water and sewage expenses;
- Phone expenses;
- Dependent care expenses;
- Homeowner's Insurance;
- Utility expenses (gas/electric/oil);
- Garbage expenses;
- Medical expenses;
- Child support expenses paid to children who do not live in your household.

Do You Need Child Care?



Please tell us why you need child care?

- Working High School or GED completion
- Education/training (as part of DSS Employment & Training Program (E&T))
- Health (explain): _____
- Other (explain): _____

Child(ren)'s Name(s) Needing Child Care	How many hours needed?	Provider name, address and phone number	Provider ID number	DHSS Provider Or Self-arranged	Date Care Began

Is Anyone in Your Household in School?



Complete this section for Cash Assistance, Food Supplement, and Child Care Only

Complete the table for anyone in your household attending school, including trade school.

Person(s) In School	Name of School	Full/Part Time	Grade	Expected Graduation Date if 16 or Older

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1-800-230-PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1-800-499-WAIT (9248). You can also call the Delaware Helpline at 211 or 1-800-464-4357 for the Public Health Family Planning clinic in your area.

Penalties



For the Food Supplement, Cash and Medical Assistance Programs

Although providing Social Security Numbers is voluntary, you understand that if you fail to give Social Security Numbers you or a member of your household may be denied services. Your Social Security Number will be used to determine initial and ongoing eligibility. Non-lawful aliens are not required to give a Social Security Number.

We will use your Social Security Number to check information in our records with other Federal, State, and Local agency computer matching systems. If you give us false information on purpose, we will take legal action against you.

If you receive benefits that you should not get, you will be responsible to repay those benefits during your period of eligibility and after you are no longer receiving benefits.

An individual will not be able to get Food Benefits or Cash Assistance if:

- he/she is fleeing to avoid prosecution, custody or confinement after a conviction that is a felony, or
- violating a condition of probation or parole imposed under a Federal or State law



Penalties in the Cash Assistance Program

Do Not give false information or hide information to get or continue to get Cash Assistance.

If...	You will ...
<ul style="list-style-type: none"> ▪ Any member of your household breaks a Temporary Assistance for Needy Families (TANF) rule on purpose 	<ul style="list-style-type: none"> ▪ lose cash assistance for 12 months for the first violation ▪ lose cash assistance for 24 months for the second violation ▪ lose cash assistance permanently for the third violation
<ul style="list-style-type: none"> ▪ Any applicant or recipient gives false information in order to obtain benefits 	<ul style="list-style-type: none"> ▪ be subject to penalties that include a fine of up to \$500 and imprisonment up to 6 months
<ul style="list-style-type: none"> ▪ Any member of your household is found guilty of misrepresenting his or her place of residence in order to get multiple benefits in two or more states for the same month from programs funded under TANF 	<ul style="list-style-type: none"> ▪ lose cash assistance for 10 years
<ul style="list-style-type: none"> ▪ Any member of your household is convicted of a felony for having, using, or selling controlled substances 	<ul style="list-style-type: none"> ▪ lose cash assistance permanently

TANF Job Quit Penalties

If an individual quits a job without good cause the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.

TANF Work and Training Penalties

When an individual does not comply with work and training the entire TANF case will close for one month or until the individual meets work and training requirements for four weeks in a row, whichever is later.



Penalties in the Food Supplement Program

If you...	You will lose food benefits...
<ul style="list-style-type: none">▪ Hide information or make false statements▪ Use EBT cards that belong to someone else▪ Use food benefits to buy alcohol or tobacco▪ Trade or sell benefits or EBT cards	<ul style="list-style-type: none">▪ 12 months for the first offense▪ 24 months for the second offense and▪ permanently for the third offense
<ul style="list-style-type: none">▪ Trade food benefits for controlled substances, such as drugs	<ul style="list-style-type: none">▪ for 24 months for the first offense and▪ permanently for the second offense
<ul style="list-style-type: none">▪ Trade food benefits for firearms, ammunition or explosives	<ul style="list-style-type: none">▪ Permanently
<ul style="list-style-type: none">▪ Trade, buy or sell food benefits of \$500 or more	<ul style="list-style-type: none">▪ Permanently
<ul style="list-style-type: none">▪ Give false information about who you are and where you live so you can get extra food benefits	<ul style="list-style-type: none">▪ 10 years for each offense

You can also be fined up to \$250,000 or put in prison for up to 20 years or both, for doing these things. You may also be charged under Federal laws.

The information you give us will be checked to make sure your household is eligible for food benefits and Cash Assistance. Federal, State, and Local officials will check the information you give us. The information you give us may also be checked by other Federal Aid programs and Federally-Aided State programs, such as School Lunch and Medicaid. If any information given is found to be incorrect, you may be denied Food Benefits/Cash Assistance. If you give false information on purpose, legal action may be taken against you. You may also have to pay back the amount of benefits you should not have received.



For Food Benefits Nondiscrimination Statement

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.
USDA is an equal opportunity provider and employer.



For Cash Assistance, Medical Assistance, and Child Care Nondiscrimination Statement

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

What You Need To Know About the Medical Assistance Program



For the Food Supplement, Cash and Medical Assistance Programs

I understand and agree:

- I will apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation, Social Security, or Medicare.
- By law, as a condition of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS.
- To allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance. This will allow DHSS to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.
- I confirm that no one applying for medical assistance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated. I understand that I cannot receive Medical Assistance or CHIP benefits while incarcerated.

We need this information to check your eligibility for help paying for medical assistance if you choose to apply. Your answers will be checked using information from electronic databases. If the information does not match, you may be asked to send proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next 5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

I understand and agree:

- I will automatically receive child support services from the Division of Child Support Enforcement (DCSE).
- I must cooperate with DCSE in establishing paternity and obtaining medical support for any child receiving medical assistance.
- DCSE is authorized to deduct directly from my support payments, any and all monies owed to the Division of Social Services.
- I will not be eligible for benefits if I fail to cooperate with DCSE unless a good cause is established. My child(ren) may still be eligible.
- Pregnant women are not required to cooperate in establishing paternity and obtaining medical support.

Some Medicaid programs require you to enroll in a managed care organization.

To enroll in a managed care organization (MCO), call the Health Benefits Manager at 1-800-996-9969.

Disclosure of Information

For All Programs

All information and documentation gathered for determining your Cash Assistance, Food Supplement, Child Care and Medical Assistance eligibility or other program related use is confidential. Each program provides safeguards, restricting the use and disclosure of information about you to purposes directly connected with the administration of the program.

Releasing information concerning your eligibility to anyone not authorized to receive the information is a violation of State and Federal law and may result in legal action.

We will keep your eligibility information confidential, unless you give us permission to release information to others.

Certifications and Signatures

Certification of Citizenship and Alien Status

I certify, under penalty of perjury, that I, and any other members of my household, are U.S. citizens or aliens in lawful immigration status. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

Certification of Head of Household Selection

I have read and have had explained to me the provisions about selecting a head of household. I have selected the following person to be the head of household and I certify that all adult members in my household agree to this selection.

(Head of Household Designee)

Certification of Understanding and Accuracy of Application Answers

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. I certify, under penalty of perjury, that all my answers are correct and complete including information about the citizenship or alien status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand and agree that DHSS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

I have read, or have had read to me, all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I

understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I agree to allow Delaware Health and Social Services, or its representatives, to act as my agent in recovering money spent by its medical assistance programs when other money from insurance, estates, etc. is available to pay my medical bills.

I have a right to request a Fair Hearing if I am not satisfied with any decision made about my eligibility or benefits. An attorney or any other person I choose may represent me.

I have read, or had read to me, and understand the current Rights and Responsibilities. I have received a copy of the Rights and Responsibilities from the DHSS worker.

The person who filled out step 1 should sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in Appendix C.

Applicant's Signature

Date

Witness

Authorized Representative's Signature

Date

Witness

Spouse/Partner's Signature
(Not required for medical assistance)

Date

Witness

For Persons Who Cannot Speak English

Translation services were offered or a family member or other person was present to translate.



Translator's Signature

Date

Phone Number & Agency/Relationship



Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last) 2. Employee Social Security number

EMPLOYER Information

3. Employer name 4. Employer Identification Number (EIN) 5. Employer address 6. Employer phone number 7. City 8. State 9. ZIP code 10. Who can we contact about employee health coverage at this job? 11. Phone number (if different from above) 12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: Name: Name:

No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard? Yes (Go to question 15) No (Stop and return form to employer)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of the allowed benefit costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986) Effective Date: 3/01/2014 Delaware FORM 100-17

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
--	------------------------------------

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number () -	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) () -		12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____
(mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes (Go to question 15) No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
	First	Middle	First	Middle
1. Name (First Name, Middle Name, Last Name)	Last		Last	
2. Member of a federally recognized tribe?	Yes If yes, tribe name		Yes If yes, tribe name	
	No		No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Yes		Yes	
	No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No		No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance 	\$ _____ How often? _____		\$ _____ How often? _____	



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)



Apply faster online

Apply faster online at www.assist.dhss.delaware.gov
This includes anyone wishing to apply for Medical Assistance only.



Who can use this application?

- Use this application to apply for anyone in your home including any tax dependents who are out of the home.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If applying for Medical Assistance only, you may be able to use a short form.



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants)
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family. You may need to complete Appendix A.



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**



What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps. If you don't hear from us, call 1-800-372-2022.



Get help with this application

- **Phone:** Call our Customer Relations Unit at **1-800-372-2022**.
- **In person:** There may be social workers/case managers in your area who can help.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-866-843-7212**.
- **In a language other than English:** Call **1-866-843-7212**.
- **TTY users:** Call **711** or **1-800-232-5460**.



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing Medical Assistance Programs that include:

- free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- doctors, hospitals, prescriptions, labs, and x-rays
- affordable, private health insurance plans through the Marketplace
- a new tax credit that can immediately help pay your premiums for health coverage

We can provide information about other helpful services in your community. A friend or relative, or anyone that you wish, may help you complete this application. If you wish to have someone else manage your case and act as your representative, please complete Appendix C.

Your application is not complete until you sign the last page. Return the application to us.

STEP 1 Tell us about yourself.

(We need one adult in the household to be the contact person for your application.)

First name, Middle name, Last name, & Suffix			
Home Address			Apartment or suite number
City	State	Zip Code	
Mailing address (if different from home address)			Apartment or suite number
City	State	Zip Code	
Primary Phone Number () -		Secondary Phone Number () -	
Preferred Methods of Contact			
I want to receive information about this application and future communication by: <input type="checkbox"/> Email Address <input type="checkbox"/> U.S. Mail			
E-Mail Address: _____			
Preferred spoken or written language (if not English)			

STEP 2

Tell us about yourself and the people in your household.

Are you? Single Married Divorced Separated Civil Union Widowed Unmarried Partnership

Instructions

Fill in the blocks for all of the people who live with you. If you file taxes, we need to know about everyone on your tax return.

Race: B = Black/African American
 PI = Native Hawaiian/Pacific Islander
 I = American Indian/Alaskan Native (If anyone in your household is American Indian/Alaskan Native, also complete Appendix B.)
 W=White
 A=Asian
Ethnic Group: H=Hispanic/Latino
 N=Non-Hispanic/Latino

Last Name	First Name, Middle Name	Relation to you	Are you applying for this person?	Sex M/F	Birth Date mm/dd/yyyy	Social Security Number*	Race/Ethnic Group (optional)	U.S. Citizen? Answer for applicants only. **
		Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No

*We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

** Applies to applicants for health coverage only.

Complete this section for legal alien applicants only.

1. Do applicants have eligible immigration status? Yes. Complete the section below.

Name	Immigration Document Type	Document ID number	Have you lived in the U.S. since 1996?	Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

2. Does any child under the age 18 applying have an absent parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Are there any children under the age 19 living in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, fill in below.	
Parent or Caregiver's Name	Child's Name

STEP 3 Tell us about your health care.

Is anyone in your household offered health coverage from a job (even if the coverage is from someone else's job, such as a parent or spouse)? If yes, you'll need to complete Appendix A. Yes No

Is this a state employee benefit plan? Yes No

Other than Medicaid does anyone in your household have health insurance or Medicare? Yes No

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	
4. Name anyone in your household who is pregnant _____ due date _____ How many babies are expected during this pregnancy? _____				
5. Name anyone who has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home _____				
6. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.)				
7. Does anyone plan to file a tax return for current year? <input type="checkbox"/> Yes <input type="checkbox"/> No (You can still apply for medical assistance even if you don't file a tax return.) If yes, please fill in below and answer questions A. If no, skip to question B.				
Name of Tax Filer	Who will be claimed as a Tax Dependent			
A. Will anyone file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____				
B. Will you be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer and how you are related to the tax filer: _____				
8. Name anyone in your household who was in Delaware Foster Care at age 18 or older and received Delaware Medicaid Benefits:				

STEP 4

Tell us about the money people in your household get.

- EMPLOYED START AT QUESTION #9 (If anyone is currently employed, tell us about his or her income.)
 SELF EMPLOYED SKIP TO QUESTION #19
 NOT EMPLOYED SKIP TO QUESTION # 21

CURRENT JOB 1

9. Please list the person's name:

10. Employer name and address

11. Employer phone number

() -

12. Wages/tips/commissions (before taxes) Hourly Weekly Every 2 weeks Twice a Month Monthly Yearly

\$ _____

13. Average hours worked each WEEK

CURRENT JOB 2

14. Please list the person's name:

(If you have more jobs and need more space, attach another sheet of paper.)

15. Employer name and address

16. Employer phone number

() -

17. Wages/tips/commissions (before taxes) Hourly Weekly Every 2 weeks Twice a Month Monthly Yearly

\$ _____

18. Average hours worked each WEEK

SELF EMPLOYMENT

19. Please list the person's name:

20. If self-employed, answer the following questions:

- a. Type of Work _____
 b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? \$ _____

OTHER INCOME THIS MONTH

21. Check all that apply, and the amount and how often you get it.

None

Where does money come from	Who gets the money?	How much do they get?	How often are they paid?
<input type="checkbox"/> Unemployment Compensation		\$	
<input type="checkbox"/> Pensions		\$	
<input type="checkbox"/> Social Security		\$	
<input type="checkbox"/> Retirement Accounts		\$	
<input type="checkbox"/> Alimony received		\$	
<input type="checkbox"/> Net farming/fishing		\$	
<input type="checkbox"/> Net rental/royalty		\$	
<input type="checkbox"/> Other income		\$	

CHANGE IN EMPLOYMENT

22. In the past year, did anyone: Change jobs Stop working Start working fewer hours None of these

STEP 5

Tell us about your tax deductions.

Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 20b).

- Allimony paid \$ _____ How often? _____
- Student loan interest \$ _____ How often? _____ Type: _____
- Other tax deductions * \$ _____ How often? _____

*For other potential deductions, refer to your current tax return form 1040 under the Adjusted Gross Income section.

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1-800-230-PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1-800-499-WAIT (9248). You can also call the Delaware Helpline at 211 or 1-800-464-4357 for the Public Health Family Planning clinic in your area.

STEP 6

Read & sign this application.

RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that Delaware Health and Social Services (DHSS) may contact other persons or organizations to obtain the necessary proof of my eligibility.

I must give the Social Security Number for each person applying and it will be used to check records with other government agencies. DHSS also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow DHSS, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills.

I may have to repay to DHSS any medical assistance received for which I am not entitled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law, as conditions of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS, and I understand I must cooperate with the Division of Child Support Enforcement in establishing paternity and obtaining medical support for any child receiving medical assistance.

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient, I will automatically receive full child support services from the Division of Child Support Enforcement, unless I state that I want to receive only child support services related to medical support.

I understand that if I am a Medicaid or Delaware Healthy Children Program applicant/recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for medical assistance in order to administer the medical assistance program,

coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with U.S. Citizenship and Immigration Services (USCIS). Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligibility, such as a change in how many people live with me, a new job or change in income, or if I move.

- I confirm that no one applying for medical assistance on this application is incarcerated, detained or jailed.
- If not, _____ is incarcerated. I understand that I cannot receive Medicaid Assistance or CHIP benefits while incarcerated.

RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow DHSS to use income data, including information from tax returns. DHSS will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

- 5 years (the maximum number of years allowed), or for a shorter number of years:
- 4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

I have received the "Rights and Responsibilities" and understand what it means.

Signature of Applicant or Representative _____
Date

FOR PERSONS WHO CANNOT SPEAK ENGLISH
Translation services were offered or a family member or other person was present to translate.

Signature of Translator _____
Date _____
Phone Number & Agency/Relationship

STEP 7 Assistance with Completing this Application - Optional

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Delaware Health and Social Services (DHSS). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip Code
7. Phone number () —		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get information about this application, and act for you on all future matters with this agency.		
10. Your Signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

STEP 8 Mail completed application.

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.



Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last) 2. Employee Social Security number

EMPLOYER Information

3. Employer name 4. Employer Identification Number (EIN) 5. Employer address 6. Employer phone number 7. City 8. State 9. ZIP code 10. Who can we contact about employee health coverage at this job? 11. Phone number (if different from above) 12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: Name: Name:

No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard? Yes (Go to question 15) No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986) Effective Date: 3/01/2014

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
--	------------------------------------

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number () -	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) () -		12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____
(mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes (Go to question 15) No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



Delaware Health and Social Services (DHSS) APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
1. Name (First Name, Middle Name, Last Name)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	Yes If yes, tribe name		Yes If yes, tribe name	
	No		No	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Yes		Yes	
	No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No		No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance 	\$ _____ How often? _____		\$ _____ How often? _____	



Welcome to the State of Delaware Health and Social Services (DHSS)



Apply faster online

Apply faster online at
www.assist.dhss.delaware.gov



Use this application to see what coverage you qualify for

- Free or low-cost insurance from Medicaid or CHIP
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage



Who can use this application?

Single adults who:

- Don't have any dependents and can't be claimed as a dependent on someone else's tax return
- Aren't offered health coverage from their employer
- Only declare a tax deduction for student loan interest

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You're American Indian or Alaska Native.

NOTE: You can choose an authorized representative to assist you with completing this application. Complete Step 5.



What you may need to apply

- Your Social Security Number (or document number if you're a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private, as required by law.**



What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- If you have questions, please call 1-800-372-2022.
- If you need help with translation call 1-866-843-7212.
- For TTY call 711 or 1-800-232-5460.
- En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212.



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR HEALTH COVERAGE
AND HELP PAYING COSTS (SHORT FORM)

Welcome to the State of Delaware Health and Social Services (DHSS)

STEP 1 Tell us about yourself.

1. First name, Middle name, Last name, & Suffix		
2. Home Address (Leave blank if you don't have one.)		3. Apartment or suite number
4. City	5. State	6. Zip Code
7. Mailing address (if different from home address)		8. Apartment or suite number
9. City	10. State	11. Zip Code
12. Primary Phone Number () -		13. Secondary Phone Number () -
14. Preferred Methods of Contact I want to receive information about this application and future communication by: <input type="checkbox"/> Email Address <input type="checkbox"/> U.S. Mail E-Mail Address: _____		
15. Do you plan to stay in Delaware? <input type="checkbox"/> Yes <input type="checkbox"/> No		
16. Date of birth (mm/dd/yyyy)		17. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
18. Social Security number (SSN) ____ - ____ - ____ We need this if you want health coverage and have an SSN. We use SSN's to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.		
19. Ethnicity: (OPTIONAL) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
20. Race (OPTIONAL – check all that apply.) <input type="checkbox"/> Alaskan <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White		
21. Are you a U.S. Citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
22. If you are not a U.S. Citizen or U.S. national, do you have eligible immigration status? <input type="checkbox"/> Yes - Fill in your document type and ID number below. a) Immigration document type _____ b) Document ID number _____ c) Have you lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No d) Are you a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
23. Preferred spoken or written language (if not English)		
24. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many babies are expected during this pregnancy? _____ What is your expected due date? _____		
25. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
26. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much do you pay? \$ _____ How often? _____		
27. Were you in Delaware Foster Care at age 18 or older and receiving Delaware Medicaid Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		

STEP 2

Tell us about your health care.

1. Are you enrolled in health coverage now? Yes No

If yes, check which coverage you have:

Medicaid

CHIP

Medicare

TRICARE (don't check if you have Direct Care or Line of Duty)

Peace Corps

VA health care programs

Other
Name of health insurance

Policy number

STEP 3

Tell us about your income.

EMPLOYED START AT QUESTION #1

SELF EMPLOYED START AT QUESTION # 9

NOT EMPLOYED START AT QUESTION # 10

CURRENT JOB 1

1. Employer name and address

2. Employer phone number

3. Average hours worked each week

() -

4. Wages/tips/commissions (before taxes) Hourly Weekly Every 2 weeks Twice a Month Monthly Yearly

\$ _____

CURRENT JOB 2 (If you have more jobs and need more space, attach another sheet of paper.)

5. Employer name and address

6. Employer phone number

7. Average hours worked each week

() -

8. Wages/tips/commissions (before taxes) Hourly Weekly Every 2 weeks Twice a Month Monthly Yearly

\$ _____

SELF EMPLOYED

9. Type of Work _____

How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\$ _____

OTHER INCOME THIS MONTH

10. Check all that apply, and give the amount and how often you get it.

None

	Amount	How Often		Amount	How Often
<input type="checkbox"/> Unemployment Compensation	\$ _____	_____	<input type="checkbox"/> Alimony received	\$ _____	_____
<input type="checkbox"/> Pensions	\$ _____	_____	<input type="checkbox"/> Net farming/fishing	\$ _____	_____
<input type="checkbox"/> Social Security	\$ _____	_____	<input type="checkbox"/> Net rental/royalty	\$ _____	_____
<input type="checkbox"/> Retirement Accounts	\$ _____	_____	<input type="checkbox"/> Other Income	\$ _____	_____

Type _____

CHANGE IN EMPLOYMENT

11. In the past year, did you: Change jobs Stop working Start working fewer hours None of these

STEP 4

Read & sign this application.

RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that Delaware Health and Social Services (DHSS) may contact other persons or organizations to obtain the necessary proof of my eligibility.

I must give the Social Security Number for each person applying and it will be used to check records with other government agencies. DHSS also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow DHSS, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills.

I may have to repay to DHSS any medical assistance received for which I am not entitled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law, as conditions of eligibility, I assign all rights to medical support and to payment for medical care from any third party to DHSS, and I understand I must cooperate with the Division of Child Support Enforcement in establishing paternity and obtaining medical support for any child receiving medical assistance.

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient, I will automatically receive full child support services from the Division of Child Support Enforcement, unless I state that I want to receive only child support services related to medical support.

I understand that if I am a Medicaid or Delaware Healthy Children Program applicant/recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow DHSS, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for medical assistance in order to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with U.S. Citizenship and Immigration Services (USCIS). Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligibility, such as a change in how many people live with me, a new job or change in income, or if I move.

- I confirm I am not incarcerated, detained or jailed.
- I understand I cannot receive Medicaid/CHIP while incarcerated.

RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow DHSS to use income data, including information from tax returns. DHSS will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

I have received the "Rights and Responsibilities" and understand what it means.

Signature of Applicant or Representative

Date

FOR PERSONS WHO CANNOT SPEAK ENGLISH

Translation services were offered or a family member or other person was present to translate.

Signature of Translator

Date

Phone Number & Agency/Relationship

STEP 5

Assistance with Completing this Application - Optional

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Delaware Health and Social Services (DHSS). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip Code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get information about this application, and act for you on all future matters with this agency.		
10. Your Signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

STEP 6

Mail completed application.

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.



Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies

S10

1902(e)(14)
42 CFR 435.603

- The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size
- Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

- Yes No



Medicaid Eligibility

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

Age 19

Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Medicaid Administration

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority

A1

42 CFR 431.10

Designation and Authority

State Name:

Delaware

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency:

Delaware Health and Social Services

Type of Agency:

- Title IV-A Agency
- Health
- Human Resources
- Other

Type of Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

31 Del. C. §§ 109, 111 and 112 and chapter 5

The single state agency supervises the administration of the state plan by local political subdivisions.

Yes No

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

Yes No

TN: DE-13-0008MM

Approved: 11/19/2013

Effective: 10/01/2013



Medicaid Administration

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

- Medicaid agency
- Title IV-A agency
- An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- Medicaid agency
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

Yes No

State Plan Administration

Organization and Administration

A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

Organization and Functions of the Medicaid agency:

Delaware Government is administered under a cabinet-style arrangement similar to the Federal Government. The Department of Health and Social Services (DHSS), which is the Single State Agency responsible for the administration of the Medicaid Program consists of 12 Divisions: Child Support Enforcement, Developmental Disabilities Services, Long Term Care Residents Protection, Management Services, Medicaid & Medical Assistance (DMMA), Public Health, Aging and Adults with Disabilities, Social

TN: DE-13-0008MM Approved: 11/19/2013 Effective: 10/01/2013



Medicaid Administration

Services, State Service Centers, Adult Substance Abuse and Mental Health, Visually Impaired, and the Medical Examiner.

The Director of DMMA reports directly to the Cabinet Secretary of DHSS. In general, DMMA provides health care coverage to individuals with low incomes and those with disabilities and to ensure access to high quality, cost effective and appropriate medical care and supportive services. Medical services are provided through a managed care delivery system called the Diamond State Health Plan. Two MCOs currently deliver care to Medicaid clients. Eligibility determinations and fair hearing functions are shared between the DMMA and the Division of Social Services. DMMA administers all Medicaid eligibility policy for categorical and LTC services, while the Social Security Agency administers eligibility for SSI by way of a 1634 Agreement between the two agencies. DMMA's LTC Unit determines eligibility for LTC community or institutional clients but the Division of Social Services determines eligibility for categorically needy populations and administers the State's online eligibility application system called ASSIST. DSS also administers the Fair Hearings and Appeals processes for both eligibility and medical services. All clients who wish to appeal a denial of eligibility, termination, suspension, reduction in eligibility or services, or other action or issue where a hearing may be required as defined in 42 CFR 431.201 and 42 CFR 431.220, may file a fair hearing request directly with DSS. DSS informs DMMA of the hearing request and schedules the actual hearings. Fee-for-service clients who wish to appeal related to services would follow the same process. Managed care-enrolled clients would normally appeal directly to their MCO, and if still unsatisfied with the outcome may file for a further appeal with DMMA. Managed care clients may choose to appeal directly to DMMA and forego an appeal to their MCO. This process is also handled by DSS on behalf of DMMA. The Division of Long Term Care Residents Protection also performs fair hearings for any nursing home discharges that clients may want to contest.

While the other sister divisions within DHSS do not determine eligibility, they may provide necessary medical care for vulnerable clients who are eligible for Medicaid. For example, the Division of Substance Abuse and Mental Health provides behavioral health and substance use disorder services to adults including Medicaid clients with serious MH/SA conditions. Similarly, the Division of Developmental Disabilities Services provides rehabilitation, habilitation, day services, supported employment, and residential services for qualifying individuals many of whom are also Medicaid clients. DMMA and its sister divisions collaborate closely to deliver quality care for all individuals including those with Medicaid coverage.

Organizationally, DMMA management consists of a Director, Deputy Director, program administrators, Medical Director, Pharmacy Consultant, other nurse professionals for medical reviews and SUR functions, social workers, and other technical and clerical personnel. Medicaid claims processing for fee-for-service bills is contracted to a Fiscal Agent.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

Executive Branch Description:

While most of the State's health and human services reside within DHSS, Title IV-E services sit within the Department of Services for Children, Youth and Their Families (DSCYF). Eligibility determinations for Title IV-E foster children and adoption assistance children are delegated to DSCYF. All State Departments and Divisions administer programs and services at the State level; Delaware does not administer any State health and social service programs at a county government level. The DHSS has built State Service Centers in each of Delaware's three counties in order to provide direct access to State services. In these one-stop service centers, individuals may apply for Medicaid, apply for other Social Service programs such as Food Benefits or TANF; schedule child exams with the Division of Public Health; etc. The Service Centers are staffed with State employees who work directly with clients. DHSS employs almost 4,300 individuals and operates four long-term care facilities and the State's only psychiatric hospital, the Delaware Psychiatric Center.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

	TN: DE-13-0008MM	Approved: 11/19/2013	Effective: 10/01/2013	Remove
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Medicaid Administration

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Department for Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Not Applicable

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

- Yes No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

- Counties
- Parishes
- Other

Are all of the local subdivisions indicated above used to administer the state plan?

- Yes No

State Plan Administration

A3

Assurances

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

TN: DE-13-0008MM

Approved: 11/19/2013

Effective: 10/01/2013



Medicaid Administration

- The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- All requirements of 42 CFR 431.10 are met.
- There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid State Plan Eligibility: Summary Page (CAIS 179)

State/Territory
name:

Delaware

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

DE-13-0009

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Patient Protection and Affordable Care Act (Public Law 111-148); 42 CFR §§ 431, 435; and 45 CFR § 155

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	\$ 0.00
Second Year	2015	\$ 0.00

Subject of Amendment

State of Delaware Medicaid MAGI State Residency State Plan Amendment

Governor's Office Review

- Governor's office reported no comment
- Comments of Governor's office received

Describe:

- No reply received within 45 days of submittal
- Other, as specified

Describe:

Governor's Comments Under Separate Correspondence

Signature of State Agency Official

Submitted By:
Sharon Summers
Last Revision Date:
Nov 20, 2013
Submit Date:
Sep 11, 2013

Sharon Summers
4/27/2013
Associates Regional Administration

TN#: 13-0009MM

Approved: 11/26/2013

Effective: 01/01/2014



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Non-Financial Eligibility State Residency

S88

42 CFR 435.403

State Residency

- The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
 - Intends to reside in the state, including without a fixed address, or
 - Entered the state with a job commitment or seeking employment, whether or not currently employed.
- Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
 - Residing in the state, with or without a fixed address, or
 - The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
 - Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
 - Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
 - If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- IV-E eligible children living in the state, or



Medicaid Eligibility

Otherwise meet the requirements of 42 CFR 435.403.



Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

Yes No

The state has interstate agreements with the following selected states:

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> Alabama | <input checked="" type="checkbox"/> Illinois | <input checked="" type="checkbox"/> Montana | <input checked="" type="checkbox"/> Rhode Island |
| <input checked="" type="checkbox"/> Alaska | <input checked="" type="checkbox"/> Indiana | <input checked="" type="checkbox"/> Nebraska | <input checked="" type="checkbox"/> South Carolina |
| <input checked="" type="checkbox"/> Arizona | <input checked="" type="checkbox"/> Iowa | <input checked="" type="checkbox"/> Nevada | <input checked="" type="checkbox"/> South Dakota |
| <input checked="" type="checkbox"/> Arkansas | <input checked="" type="checkbox"/> Kansas | <input checked="" type="checkbox"/> New Hampshire | <input checked="" type="checkbox"/> Tennessee |
| <input checked="" type="checkbox"/> California | <input checked="" type="checkbox"/> Kentucky | <input checked="" type="checkbox"/> New Jersey | <input checked="" type="checkbox"/> Texas |
| <input checked="" type="checkbox"/> Colorado | <input checked="" type="checkbox"/> Louisiana | <input checked="" type="checkbox"/> New Mexico | <input checked="" type="checkbox"/> Utah |
| <input checked="" type="checkbox"/> Connecticut | <input checked="" type="checkbox"/> Maine | <input type="checkbox"/> New York | <input checked="" type="checkbox"/> Vermont |
| <input type="checkbox"/> Delaware | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> North Carolina | <input checked="" type="checkbox"/> Virginia |
| <input checked="" type="checkbox"/> District of Columbia | <input checked="" type="checkbox"/> Massachusetts | <input checked="" type="checkbox"/> North Dakota | <input checked="" type="checkbox"/> Washington |
| <input checked="" type="checkbox"/> Florida | <input checked="" type="checkbox"/> Michigan | <input checked="" type="checkbox"/> Ohio | <input checked="" type="checkbox"/> West Virginia |
| <input checked="" type="checkbox"/> Georgia | <input checked="" type="checkbox"/> Minnesota | <input checked="" type="checkbox"/> Oklahoma | <input checked="" type="checkbox"/> Wisconsin |
| <input checked="" type="checkbox"/> Hawaii | <input checked="" type="checkbox"/> Mississippi | <input checked="" type="checkbox"/> Oregon | <input type="checkbox"/> Wyoming |
| <input checked="" type="checkbox"/> Idaho | <input checked="" type="checkbox"/> Missouri | <input checked="" type="checkbox"/> Pennsylvania | |

The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- Are IV-E eligible
- Are in the state only for the purpose of attending school
- Are out of the state only for the purpose of attending school
- Retain addresses in both states
- Other type of individual

	Name of Type	Description	
+	Children with Special Needs	Children with Special Needs under a state funded Adoption Subsidy Agreement: These Children with Special Needs for whom there is a signed state-funded Adoption Subsidy Agreement are included under our ICAMA agreement.	X
+			X

The state has a policy related to individuals in the state only to attend school.



Medicaid Eligibility

Yes No

Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

Yes No

Provide a description of the definition:

Temporary Absences Out of State

An individual may be found eligible and remain eligible during a temporary absence if the individual intends to return when the purpose of the absence has been accomplished unless another state has determined that the person is a resident there for purposes of Medicaid.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42

CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

The state provides Medicaid eligibility to otherwise eligible individuals:

Who are citizens or nationals of the United States; and

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity

Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

Yes No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

Yes No

The date benefits are furnished is:

The date of application containing the declaration of citizenship or immigration status.

The date the reasonable opportunity notice is sent.

Other date, as described:



Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

Yes No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

Yes No

Pregnant women

Individuals under age 21:

Individuals under age 21

Individuals under age 20

Individuals under age 19

An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

Granted employment authorization under 8 CFR 274a.12(c);

Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

Granted Deferred Action status;

Granted an administrative stay of removal under 8 CFR 241;

Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

Has been granted employment authorization; or

TN No. 3000001 the age of 14 and has had APPROVED DATE 07/06/2013 at least 180 days; EFFECTIVE DATE 01/1/2014



Medicaid Eligibility

6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));
10. **Exception:** An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

Other

The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

Yes No

The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A qualified hospital is a hospital that:

Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

Yes No

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

Pregnant Women

Infants and Children under Age 19

Parents and Other Caretaker Relatives

Adult Group, if covered by the state

Individuals above 133% FPL under Age 65, if covered by the state

Individuals Eligible for Family Planning Services, if covered by the state

Former Foster Care Children

Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

Other Family/Adult groups:

Eligibility groups for individuals age 65 and over

Eligibility groups for individuals who are blind

Eligibility groups for individuals with disabilities

Other Medicaid state plan eligibility groups

Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.



Medicaid Eligibility

Yes No

The presumptive period begins on the date the determination is made.

The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

Periods of presumptive eligibility are limited as follows:

No more than one period within a calendar year.

No more than one period within two calendar years.

No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

Yes No

The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

The presumptive eligibility determination is based on the following factors:

The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is

being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

State residency

Citizenship, status as a national, or satisfactory immigration status

The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement



Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)

Application for Hospital Presumptive Eligibility for Medicaid

You can use this form to apply if you are a patient of the hospital, a patient's family member, or a community member.

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility is a temporary determination that gives you immediate access to health care while you wait for a regular Medicaid determination. You can apply for regular Medicaid on line at www.assist.dhss.delaware.gov, by telephone, in-person in your area, or by mail.

Who can qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet all of these rules:

- Your income is below the monthly limit
- You are a U.S. citizen, U.S. national, or eligible immigrant
- You do not already have Medicaid
- You have not had presumptive eligibility for Medicaid in the past 12 months. Or, if you are pregnant, you have not had presumptive eligibility for Medicaid during this pregnancy.
- You are in one of the groups that qualifies for presumptive eligibility for Medicaid:
 - Children under age 19
 - Parents and caretaker relatives
 - Pregnant women
 - Other adults age 19-64
 - People under age 26 who were in foster care at age 18 (no income limit)
 - Women in treatment for breast and cervical cancer

Need help with your application for regular Medicaid?

- Phone: Call our Customer Relations Unit at 1-800-372-2022.
- In person: There may be social workers/case managers in your area who can help.
- En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212.
- In a language other than English: Call 1-866-843-7212.
- TTY users: Call 711 or 1-800-232-5460.

1

Tell us about yourself

We ask for this information so that we can contact you about this application.

Name (first, middle, last)

Home address (leave blank if you don't have one)

City

State

ZIP code

Mailing address (if different from home address)

Primary Phone Number (if you have one)

Secondary Phone Number (if you have one)

Preferred Methods of Contact

I want to receive information about this application and future communication by: Email Address U.S. Mail

Email Address: _____

Preferred Spoken or written Language (if not English)

2

Tell us about your family

List yourself and the members of your immediate family who live with you. Include your spouse and your children under 19 if they live with you. Do not list other relatives or friends even if they live with you.

Name (first, middle, last)	Date of birth (XX/XX/XXXX)	Relationship to you	Applying for presumptive eligibility for Medicaid? (Yes or No)	Already has Medicaid? (Yes or No)	U.S. Citizen, U.S. National, or eligible immigrant? (Yes or No)	Resident of Delaware? (Yes or No)
Answer for family members who are applying. If a person is not applying, you do not have to answer these questions for that person.						
(Same as above)		(Self)				

3

Other questions

Answer these questions for yourself and your family members listed in Section 2. Your answers will make it easier to find out if you and any family members qualify.

Is anyone pregnant, even if she is not applying for presumptive eligibility for Medicaid? [] Yes [] No

If yes, who? _____ How many babies does she expect? _____

Is anyone who is applying for presumptive eligibility for Medicaid receiving Medicare? [] Yes [] No

If yes, who? _____

Is anyone who is applying for presumptive eligibility for Medicaid a parent or caretaker relative? [] Yes [] No
For example, a grandparent who is the main person taking care of a child.

If yes, who? _____

Was anyone who is applying for presumptive eligibility for Medicaid in foster care at age 18 or older and received Delaware Medicaid? [] Yes [] No

If yes, who? _____

Is anyone who is applying for presumptive eligibility for Medicaid being treated for breast or cervical cancer? [] Yes [] No

If yes, who? _____

4

Tell us about your family's income

Write the total income before taxes are taken out for all family members listed in Section 2.

Job income For example, wages, salaries, and self-employment income.

Amount \$ _____ How often? (check one) [] Weekly [] Biweekly [] Monthly [] Yearly

Other income For example, unemployment checks, alimony, or disability payments from the Social Security Administration ("SSDI"). Do not include Supplemental Security Income ("SSI payments") or any child support you receive.

Amount \$ _____ How often? (check one) [] Weekly [] Biweekly [] Monthly [] Yearly

5

Sign this form here

By signing, you are swearing that everything you wrote on this form is true as far as you know. We will keep your information secure and private.

Signature and Date fields for the applicant and authorized representative.

6**If you qualify for presumptive eligibility for Medicaid, what happens next?**

- You will get a letter from the hospital saying you were approved.
- **You can start using your presumptive eligibility for Medicaid coverage right away** for services such as doctor visits, hospital care, and prescription drugs. You can go to any health care provider who accepts Medicaid, starting the day you are approved.
 - To start using your presumptive eligibility for Medicaid the hospital will give you a letter saying you are approved. Use the letter to get services until you get a card in the mail. If you lose the letter, you can call 1-800-372-2022.
 - If the letter says you qualify for presumptive eligibility for Medicaid because you are pregnant, you can get care at outpatient clinics or other places in the community. Presumptive eligibility for Medicaid will not cover the cost if you are admitted to a hospital.
- If you do not fill out and send the application for medical assistance to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved
 - ➔ For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.
- **To see if you qualify for regular Medicaid or other health coverage,**
 - The hospital will give you an application for regular Medicaid.
 - Phone: Call our Customer Relations unit at 1-800-372-2022.
 - In person: There may be social workers/case managers in your area who can help.
 - En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212
 - In a language other than English: Call 1-866-843-7212
 - TTY users: Call 711 or 1-800-232-5460.

7**If you do not qualify for presumptive eligibility for Medicaid, what happens next?**

You will get a letter from the hospital saying you were not approved. You cannot appeal the hospital's decision. BUT, you can still apply for regular Medicaid or other health coverage using the application for medical assistance.



Proof of Temporary Coverage for Presumptive Eligibility

Dear Provider:

The person(s) listed below has temporary health coverage through Presumptive Eligibility (PE). Temporary coverage may last between 30 and 60 days depending on the effective date of coverage shown (below). To ensure payment, providers must verify eligibility prior to providing services and submitting claims. If you have questions concerning Presumptive Eligibility, please call the DHSS Customer Relations Unit at 1-800-372-2022.

Verify Presumptive eligibility via:

- Delaware Medical Assistance Program Website www.dmap.state.de.us
Click on the Interactive Services tab and enter your web user ID and password. If a provider has not registered to use the interactive services tab, they can register at <https://www.dmap.state.de.us/secure/emailIntro.do>
- Provider Relations 1-800-999-3371 Option 0, then # 2

Services included under temporary coverage are the same as those available under regular program coverage.

NOTE: Social Security Numbers are requested **but are not required**.

Name (First - Middle Initial - Last)	Social Security Number AND Date of Birth mm/dd/yyyy	Effective Date of Coverage mm/dd/yyyy	Check the appropriate coverage group				
			Parent/ Caretaker Relative	Pregnant Women	Infants and Children under age 19	Adults	Former Foster Children

Name of Qualified Entity Determining Presumptive Eligibility (Please Print)

Date

Signature of Qualified Entity

Qualified Entity: Within 5 days of Determination FAX PE Application and Proof of Temporary Coverage form to:
DHSS at 1-866-843-7212.

Delaware Health and Social Services (DHSS), PO BOX 906, New Castle, DE 19720

The Medicaid Hospital Based Presumptive Eligibility (PE) Program

Delaware Health and Social Services
Division of Medicaid and Medical Assistance



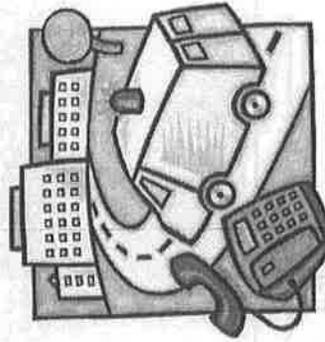
TN No. 14-0006 MM7

Approval Date: 6/26/2014

Effective Date: 1/1/2014

Contents

- * In this training, the following will be covered:
 - * Overview of the Hospital Presumptive Program
 - * Terms and Definitions
 - * Eligibility Requirements
 - * Household Composition
 - * Income
 - * Process of completing a Presumptive Eligibility Determination.
 - * Finalizing the Presumptive Eligibility Process.



Hospital Presumptive Overview

- * What is Hospital Based Presumptive Eligibility?
 - * With new Medicaid regulations taking effect 1-1-2014, hospitals will have the option to participate in the Hospital Based Presumptive Eligibility Program. This program allows qualified hospitals to provide presumptive Medicaid eligibility to individuals based on preliminary declared information (income, citizenship/immigration status, and residence).
 - * Individuals approved will be eligible for Medicaid services during a temporary presumptive time period.

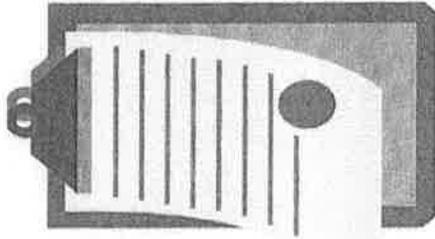
Hospital Presumptive Overview

- * Frequency Limitations:
 - * Presumptive eligibility determinations are limited to no more than one period within a 12-month period starting with the effective date of the initial PE period.
 - * A pregnant woman may be authorized for presumptive eligibility once per pregnancy.



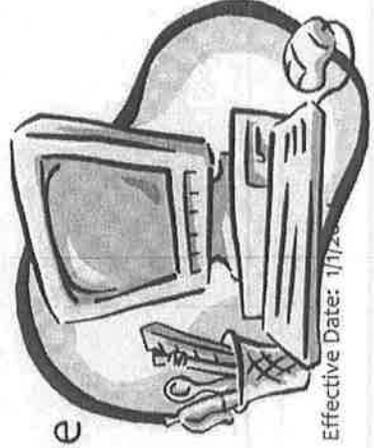
Hospital Presumptive Overview

- * **Qualified Entity Responsibilities:**
- * Notify the appropriate individual at the time a determination regarding presumptive eligibility is made, in writing or orally if appropriate, of such determination, that –
 - * If a Medicaid application on behalf of the eligible individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day.
 - * If a Medicaid application on behalf of the eligible individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application, and
 - * If the individual is not determined presumptively eligible, the qualified entity shall notify the appropriate individual of the reason for the determination and that he or she may file an application for Medicaid with the Medicaid agency.



Hospital Presumptive Overview

- * Qualified Entity Responsibilities (cont.)
- * Provide the individual with the Delaware Health and Social Services Application for Presumptive Eligibility for Medicaid;
- * Within five working days after the date that the determination is made, notify the agency that the individual is presumptively eligible; and
- * Shall not delegate the authority to determine presumptive eligibility to another entity.



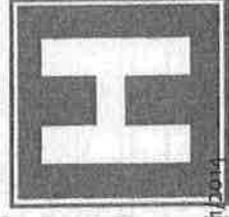
Effective Date: 1/1/2014

Approval Date: 6/26/2014

TN No. 14-0006 MM7

Hospital Presumptive Overview

- * Qualified Hospital Criteria:
- * Participate as a Medicaid Provider;
- * Notify Delaware Health and Social Services of its decision to make presumptive determinations;
- * Agree to make determinations consistent with federal and state policy and procedures; and
- * Shall not be disqualified by Delaware Health and Social Services (DHSS).



Hospital Presumptive Overview

- * Performance Standard:
- * All Hospital Presumptive Eligibility determinations will be subject to review by DHSS Quality Assurance staff. The participating hospitals will be expected to maintain a level of accuracy.
- * Hospitals not meeting this requirement will complete additional training in order to improve their accuracy. If the standards are not met after additional training, the hospital will be subject to disqualification from the presumptive eligibility program.

How to Become a Provider

1. All PE providers must be qualified Medicaid providers.
2. The provider will notify DHSS of its decision to make presumptive determinations.
3. All staff members employed by the provider who intend to make PE determinations must successfully complete PE training and sign the Confirmation of Training form. All PE training materials must be in a DHSS approved format.
4. The provider must agree to make PE determinations consistent with Delaware policy and procedure.
5. In order for a **hospital** to be accepted as a PE provider, the provider's CEO or executive director must acknowledge all staff members accepted as PE providers have successfully completed training by signing a Confirmation of Participation form.

Terms and Definitions

- * **Application Signature:** The application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18). An application may also be signed by an authorized representative.
- * **Application Submission:** Applications for regular Medicaid may be submitted in person, by mail, or by fax.

Terms and Definitions

- * **Dependent Child:** A child from birth to age 17 or who is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may be reasonably expected to complete such school or training.
- * **Eligibility Determination:** An approval or denial of eligibility.
- * **Family Size Using Modified Adjusted Gross Income (MAGI) Methodology:** Means the number of persons counted as members of an individual's household. When determining the family size of individuals who have a pregnant woman in their household, the family size is counted as the pregnant woman plus the number of children she is expected to deliver.

Terms and Definitions

- * **Modified Adjusted Gross Income (MAGI):** The methodology used to determine financial eligibility.
- * **Non-Applicant:** An individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or client's household to determine eligibility for such applicant or client.
- * **Non-Filer:** Individuals who do not intend either to file taxes or to be claimed as a tax dependent.

Terms and Definitions

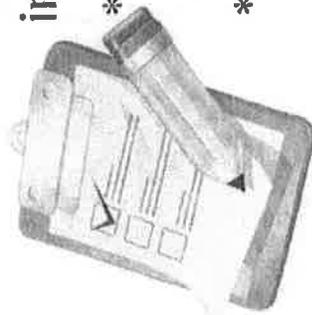
- * **Parent/Caretaker Relative:** A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:
 - * The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.
 - * The spouse of such parent or relative including same sex marriage, even after the marriage is terminated by death or divorce.
 - * Another relative of the child based on blood, adoption, or marriage; the domestic partner of the parent or caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

Terms and Definitions

- * **Tax Dependent:** An individual for whom another individual claims a deduction for a personal exemption for a taxable year.
- * **Tax Filer:** Individuals who intend to file a federal tax return for the coverage year and who do not intend to be claimed as a tax dependent by another taxpayer.

Eligibility Requirements for Presumptive Eligibility Determinations

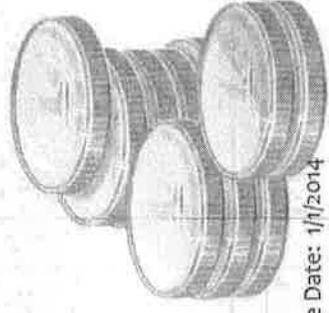
* Qualified providers will make eligibility determinations for Presumptive Eligibility based on the following preliminary information as declared by the client:



- * The individual has gross income at or below the income standard established for the applicable group;
 - * The individual has attested to being a citizen or national of the United States or is in satisfactory immigration status; and
 - * The individual is a resident of Delaware.
- * No verifications are required.

Eligibility Requirements for Presumptive Eligibility Determinations

- * **Income:**
- * In order to be determined presumptively eligible for Medicaid, an individual must declare monthly gross income at or below the income standard for their eligibility group and household size (See the attached Income Chart).
- * This calculation is made using the income included when calculating MAGI-based income.



Eligibility Requirements for Presumptive Eligibility Determinations

- * **Eligibility Groups: An Individual must fall into one of the following eligibility groups in order to be found presumptively eligible for Medicaid.**
- * **Pregnant Women**
- * **Infants and Children under age 19**
- * **Parent and Other Caretaker Relatives**
- * **Adults ages 19-64 who do not have Medicare**
- * **Former Foster Care Children – under age 26 and in Delaware Foster Care upon aging out of care**
- * **Individuals needing treatment for Breast or Cervical Cancer – screened under Centers for Disease Control Early Detection Program**

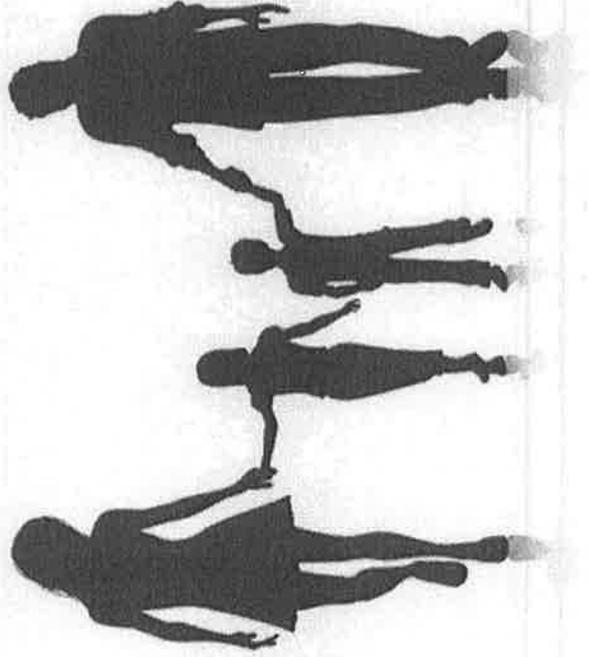
Three Step Process for Determining Income Eligibility

Apply these three steps to determine an applicant's MAGI-based income eligibility for Medicaid or CHIP:

- * Identify members of the individual's family who are considered part of his/her household and determine family size.
- * Add the income of all the relevant members of the individual's household.
- * Compare total household income to the federal poverty level for the individual's family size.

Household Composition

The household composition rules under ACA are based on the tax filing unit. Delaware has taken the State option to use non-filer rules.



Adult Non-Filer Household Rules

For adults, the household must include:

- * The adult applying for coverage: **AND**
- * The adult's married spouse if living with the individual; **AND**
- * The adult's natural, adopted, and step-children under age 19 if living with the adult.

Child(ren) Non-Filer Household Rules

Household for children under age 19 must include:

- * The child applying for coverage: **AND**
- * The child's parents (including biological, adopted, and step-parents) if living with the child; **AND**
- * Any of the child's siblings (including biological, adopted and step-siblings) who are under age 19.
- * If the child is married, the spouse (if the spouse is living with the child); and if the child has their own child, the children and step-children (if living with the married child).

Adjusting Family Size for Pregnant Women

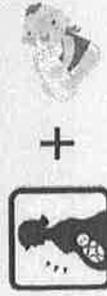
Once the household is determined, if the individual is a pregnant woman the family size must be adjusted based on the number of children she expects to deliver.

Example

Analysis

Pregnant woman expecting a single child

Family size increased by 1



Pregnant woman expecting twins

Family size increased by 2

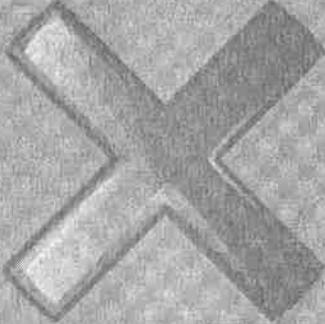


Countable Income

Countable Income	Taxable wages/salary (before taxes are taken out)
	Self-employment (profit once business expenses are paid)
	Social Security benefits
	Unemployment benefits
	Alimony received
	Most retirement benefits
	Interest (including tax-exempt interest)
	Net capital gains (profit after subtracting capital losses)
	Most investment income, such as interest and dividends
	Rental or royalty income (profit after subtracting costs)
Other taxable income, such as canceled debts, court awards, jury duty pay not given to an employer, cash support, and gambling, prizes, or awards	
Foreign earned income	

Note: Pre-tax contributions to dependent care accounts, health insurance premiums, flexible spending accounts, retirement accounts and commuter expenses are NOT included as income

Non-Countable Income

<p>Non-Countable Income</p> 	<p>Temporary Assistance to Needy Families (TANF) and other government cash assistance</p> <p>Supplemental Security Income (SSI)</p> <p>Child support received</p> <p>Veterans benefits</p> <p>Worker's compensation payments</p> <p>Proceeds from life insurance, accident insurance, or health insurance</p> <p>Federal tax credits and Federal income tax refunds</p> <p>Gifts and Loans</p> <p>Inheritances</p>
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Presumptive Determination Step by Step

1. Individual arrives for care at a qualified hospital stating they have no medical insurance.
2. Provider verifies that the individual is not currently active in Delaware Medicaid.
3. A Presumptive Eligibility Certified staff person completes the Application for Hospital Presumptive Eligibility with the individual.
4. The individual signs the presumptive form, attesting to the included citizenship, pregnancy, and income information.
5. Qualified staff person determines the household size for the individual.
6. Qualified staff person compares the household income with the FPL for the individual's Medicaid category and household size in order to determine if the individual is presumptively eligible for Medicaid (See attached income chart).

Finalizing the Presumptive Eligibility Process

1. Notify the applicant of the presumptive eligibility determination, give a copy of the application to the individual, and if the applicant is found eligible, provide the Proof of Temporary Coverage Letter. Explain to the applicant that a Notice of Decision confirming presumptive eligibility will be provided within approximately 10 days.
2. Explain to the individual that a regular application must be completed and provide the following contact information:

Phone: Call our Customer Relations Unit 1-800-372-2022

In person: There may be social workers/case managers in your area who can help.

En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212.

In a language other than English: Call 1-866-843-7212.

TTY users: Call 711 or 1-800-232-5460.

3. Within 5 working days of the presumptive eligibility determination, submit the Application for Hospital Presumptive Eligibility for Medicaid to the Delaware Health and Social Services (DHSS) via fax 1-866-843-7212. Keep the fax verification sheet as proof in case DHSS does not receive it.
4. A copy of the agency's Notice of Decision to the applicant will be provided to the hospital within approximately 10 days.

2014 Income Chart Based on Federal Poverty Level



Family Size	Annual Income 100% FPL	Monthly Income 92% FPL Parents/Caretaker Relatives	Monthly Income 138% FPL Age 6 through 18 Adults	Monthly Income 147% FPL Age 1 through 5	Monthly Income 217% FPL Pregnant Women Infants
1	11,670	896	1,392	1,479	2,160
2	15,730	1,207	1,875	1,993	2,911
3	19,790	1,518	2,359	2,508	3,662
4	23,850	1,830	2,843	3,022	4,413
5	27,910	2,141	3,327	3,536	5,165
6	31,970	2,452	3,811	4,051	5,916
7	36,030	2,764	4,295	4,565	6,667
8	40,090	3,075	4,779	5,080	7,418
9	44,150	3,385	5,262	5,593	8,168
10	48,210	3,697	5,746	6,107	8,919

* Note: There is no income test for Former Foster Care Children and Breast and Cervical Cancer Groups. A 5% FPL disregard has been added.