



COMBINED MEDICAID 103-5 Application Processing

Supersedes: MA 103-4 (07/01/03); FMA 103-5 (01/01/08); Bulletins FMA-50 and MA-89 (04/25/08)

Reference: ARM 37.82.101, .201, & .204; 42 CFR 435.911, .912, .919

Overview: All completed Medicaid applications are processed and eligibility determined in a timely manner. If the applicant voluntarily withdraws the application, document case notes with the withdrawal reason and send 'About Your Case' denial notice confirming applicant's request.

ABD Only: At application and redetermination or when a change is reported, the eligibility staff member queries all available and applicable computer systems including, but not limited to SEARCHS (child support), MISTICS (wages and unemployment), SOLQ (Social Security), property search, etc. to establish the accuracy of statements on the application, redetermination or reported change.

ABD Only: If these queries are not completed at those times, and information that would have been found by completing the system query is discovered, it is considered an agency-caused error.

However, all Family and ABD Medicaid recipients are required to report changes within 10 days of their knowledge of the change. If they fail to report a change which could have been verified through an available query, it is still a client-caused error.

NOTICES:

Written notice is sent to clients when Medicaid has been approved, changed, denied, closed, or when additional information is necessary. The approval notice states the action taken and authorized. Adequate notice is sent.

The notice of change, denial or termination states the specific reason for the change, denial or termination, the agency policy, state and federal regulations supporting the action, and the individual's right to request a fair hearing. Timely notice is sent for adverse changes and terminations, adequate notice is sent for denials.

Effective Date: July 01, 2016