

## C. Eligibility Determination Groups

One of the first steps in the eligibility determination process is forming eligibility groups. These groups identify who is considered in the household (household group), who must apply together (filing group), whose income and resources will be used to determine eligibility (financial group), whose needs are considered (need group) and who will receive benefits (benefit group). Five groups are used in making accurate eligibility determinations. However, it may not be necessary to evaluate everyone in the household in determining their eligibility for medical. Some people are assumed eligible.

### 1. Assumed Eligibility (Who is automatically eligible or has protected eligibility?)

Some individuals are *assumed eligible* for certain medical programs.

The following people are *assumed eligible* for medical assistance:

- Pregnant women who are eligible for and receiving medical assistance under any other program and become ineligible while pregnant are assumed eligible for Medicaid.
- Pregnant women who are eligible for and receiving MAA, MAF or OHP when their pregnancy ends are assumed eligible until the last day of the calendar month in which the sixtieth day after the last day of the pregnancy falls.
- A child born to a mother who is eligible for and receiving Medicaid based on MAA, MAF or OHP program eligibility (including CAWEM) is assumed eligible until the end of the month in which the child becomes one year old.
- A child who is the subject of an adoption assistance agreement with another state.
- A child in a state-subsidized, adoptive placement, if an adoption assistance agreement is in effect between a public agency of the state of Oregon and the adoptive parents that indicates the child is eligible for Medicaid.
- A recipient of SSI benefits.
- A client who receives both benefits under Part A of Medicare and SSI benefits is assumed eligible for the QMB-BAS program.
- A client is assumed eligible for REFM if –
  - The client is receiving cash assistance through the REF program;
  - The client loses eligibility for cash assistance through the REF program only because of income or resources;
  - The client loses eligibility for the EXT, MAA, MAF or SAC programs, but still meets the requirements of the REFM program; or

- The client had refugee-related medical assistance established in another state based on refugee status granted by the United States Citizenship and Immigration Services, and moved to Oregon within the client's first eight months in the United States.

Assumed Eligibility for Medical Programs: 461-135-0010

## 2. Household Group (Who is in the household?)

A household consists of people who live in the same house, apartment, or other dwelling. A dwelling can contain more than one household if it is divided into separate living units, such as an apartment house, or if a landlord/tenant relationship exists. To have a valid landlord/tenant relationship, the landlord must live independently and bill the tenant for rent at fair market value. They may share bathroom and kitchen facilities, but only in a commercial room and/or board establishment. When people live in more than one household during a month, they are considered to be living in the household where they spend 51 percent or more of their time.

A person who leaves the household for short periods is considered to still be in the household if they intend to return. If they are gone for 30 continuous days or more, they are no longer in the household unless they must still be included under one of the following:

- A parent gone because of employment while the other parent remains in the home. This includes people with jobs that customarily take them away from home, such as military service, truck driving or commercial fishing, and people looking for work.
- A parent or caretaker relative for a maximum of 90 days when they are staying in a residential alcohol or drug treatment facility.
- A person is receiving treatment in a general hospital and expected to return home. If they are not expected to return home, they remain in the household until they enter some other living arrangement, such as a nursing home.
- A child gone for illness, social service, or educational reasons. They are no longer in the household if they are admitted to a Medicaid facility such as a nursing home or residential treatment facility for more than 30 days.
- Children in foster care, if they are expected to return home within the next 30 days.

For OHP only, a child may be in a residential alcohol or drug treatment facility for more than 30 days and still be considered in the household. However, if the child's household is ineligible because of income, the child is a separate household for OHP only.

Household Group: 461-110-0210

### 3. **Filing Group (Who must apply together?)**

The filing group is the people from the household group whose circumstances are considered in the eligibility determination process. The filing group includes people who must apply together because of their relationship to eligible people.

When a household group member is in more than one filing group for the same program, the filing groups must be combined, unless specified otherwise in administrative rule.

For **EXT and MAA**, the filing group must include a dependent child or unborn.

People in the household group are included in the MAA filing group because of their relationship as follows:

- Parents of the dependent child.
- Parents of an unborn.
- Siblings of the dependent child. Siblings must be under 18 years of age or age 18 and attending school full time. (See below for exceptions for siblings receiving adoption assistance or for siblings who are minor parents.)
- For needy caretaker relatives of the dependent child, their spouse, and their dependent children.
- Caretaker relatives.

People in the household group may be excluded from the MAA filing group as follows:

- Exclude dependent children who have been or will be receiving foster care payments for more than 30 days.
- A sibling of a dependent child must be excluded from the filing group if the sibling is receiving adoption assistance.
- Allow minor parents to form a separate filing group with their dependent children when the minor parent lives with an adult relative who is not his or her parent or the parents of the minor are in the household, but are not applying for MAA for the minor parent or any of the minor parent's siblings.

For **MAF**, the filing group must include a dependent child or unborn.

People in the household group are included in the MAF filing group because of their relationship as follows:

- Parents of the dependent child.
- Mother of an unborn.

- Father of an unborn if:
    - No other dependent children are in the group; or
    - He is married to the mother; or
    - He is the father of another dependent child in the filing group.
  - Siblings of the dependent child if the siblings meet the following nonfinancial eligibility requirements:
    - Age – Under 18 years of age or age 18 and attending school full time.
    - Living with a Caretaker Relative – The caretaker must be one of the following relatives to the sibling:
      - (a) Any blood relative, including those of half-blood, and including first cousins, nephew, or nieces, and person of preceding generations as denoted by prefixes of grand, great-, or great-great.
      - (b) Stepfather, stepmother, stepbrother, or stepsister.
      - (c) A person who legally adopts the child and any person related to the person adopting the child, either naturally or through adoption.
- ☞ SEE TANF E IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES RELATED PROGRAMS CHAPTER FOR MORE INFORMATION ON DEPRIVATION.
- Citizen/Alien Status – The sibling must be a citizen of the U.S.; or be a citizen of Puerto Rico, Guam, the Virgin Islands or Saipan, Tinian, Rota or Pagan of the Northern Mariana Islands; or be a national from American Samoa or Swains Islands; or meet the alien status requirements for MAF.
- For needy caretaker relatives of the dependent child, their spouse, and their dependent children.

People in the household group may be excluded from the MAF filing group as follows:

- Exclude dependent children who have been or will be receiving foster care payments for more than 30 days.
- A sibling of a dependent child may be excluded for the filing group if the sibling is receiving adoption assistance and counting the sibling's income reduces the filing group's benefits.
- Allow minor parents to form a separate filing group with their dependent children when the minor parent lives with an adult relative who is not his or her parent.

For **OHP**, filing groups are formed from the household group as follows:

- A person forms his or her own filing group if not required to be in a filing group with another person.
- The following people are required to be in the same filing group, even if they are not applicants or do not meet all nonfinancial eligibility requirements.
  - People married to each other and each child of either spouse.
  - The parents of a child or unborn and the children of each parent.
  - Siblings under the age of 19.

*Note: A child is defined as a person, including a minor parent, under the age of 19.*

- A child whose caretaker relative is not the child's parent may form a separate filing group or may be in a group with the caretaker relative, at the option of the caretaker relative.

For **SAC**, the filing group includes only the child who meets all nonfinancial eligibility requirements.

Filing Group; Overview: 461-110-0310  
Filing Group; EXT, MAA, TANF: 461-110-0330  
Filing Group; MAF and SAC: 461-110-0340  
Filing Group; OHP: 461-110-0400

#### **4. Financial Group (Whose income and resources are counted?)**

The financial group is the filing group members whose income and resources count in determining eligibility and benefits.

For **EXT**, **MAA**, and **MAF**, the financial group includes all the people in the filing group except the following:

- Caretaker relatives (other than parents) who choose not to be included in the need group. These people are known as non-needy caretaker relatives.
- People receiving SSI benefits.

For **OHP**, the financial group includes all the people in the filing group except caretaker relatives (other than parents) who choose not to be included in the need group.

For **SAC**, the financial group (which includes the same person as in the filing group) includes only the child who meets all nonfinancial eligibility requirements.

## 5. Need Group (What income standard is used?)

The need group consists of the people whose basic and special needs are used in determining eligibility. The number in the need group determines which income standard to use.

For **MAA**, the need group includes financial group members who meet all nonfinancial eligibility requirements. Noncitizen applicants do not need to meet citizenship or alien status requirements to be eligible for CAWEM benefits. The MAA need group cannot include:

- Individuals who do not provide a Social Security number or proof they applied.
  - ☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).
- Parents who are in foster care and for whom foster care payments are being made.
- Unborn children.

For **MAF**, the need group includes all financial group members who meet all nonfinancial eligibility requirements except for the following:

- Individuals who do not provide a Social Security number or proof they applied.
  - ☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).
- Parents who are in foster care and for whom foster care payments are being made.
- The father of an unborn child who has no eligible dependent children.

For **EXT**, the need group includes all members of the financial group. Individuals who do not provide a Social Security number or proof they applied.

- ☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).

For **OHP**, the need group includes all the people in the financial group. For pregnant females, also include the unborn child(ren) in the OHP need group.

For **SAC**, the need group (which includes the same person as in the financial group) includes only the child who meets all nonfinancial eligibility requirements. Individuals who do not provide a Social Security number or proof they applied.

- ☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).

## 6. **Benefit Group (Who receives benefits?)**

The benefit group are those people who receive benefits.

For **EXT**, the benefit group consists of members of the need group who meet all financial and nonfinancial eligibility criteria.

For **MAA** and **MAF**, the benefit group includes all the need group members if the group meets the financial requirements.

For **OHP**, the benefit group consists of all the individuals who meet all the financial and nonfinancial eligibility requirements. Individuals who do not proved a Social Security number or proof they applied.

☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).

For **SAC**, the benefit group (which includes the same person as in the financial group) includes only the child who meets all nonfinancial eligibility requirements.

Benefit Group: 461-110-0750

## 7. **CAWEM**

Noncitizens who meet all the financial and nonfinancial requirements of another medical program (except OHP-HPC), except for their citizenship/alien status, are eligible for limited emergency medical assistance. The policy for forming eligibility determination groups for CAWEM is the same policy for the program the person would qualify for if they did meet the citizenship/alien status requirement.

Specific Requirements; Citizen/Alien-Waived Emergent Medical (CAWEM): 461-135-1070  
OHP-OPU; Effective Dates for the Program: 461-135-1102

This page intentionally left blank.

## **D. Nonfinancial Eligibility Requirements**

### **1. Age and School Attendance**

To be eligible for MAA, MAF, and EXT medical assistance, a child must be under 18 years of age or age 18 and regularly attending school full time. The caretaker(s) may be of any age.

To be eligible for SAC medical assistance, the person must be under age 21. There are no school attendance requirements for SAC.

When determining eligibility for OHP medical assistance, use the following age requirements for each OHP category:

- OHP-OPU: A person age 19 or older who qualifies under the 100 percent income limit.
- OHP-OPC: A person under age 19 who qualifies under the 100 percent income limit.
- OHP-OP6: A person under the age of six who qualifies under the 133 percent income limit.
- OHP-OPP: A pregnant female of any age, or their newborn children under the age of one who qualifies under the 185 percent income limit.
- OHP-CHP: A person under the age of 19 who qualifies under the 185 percent income limit.

For CAWEM, the person must meet the age and school attendance requirements of the program they would qualify for if they met the program's alien/citizen requirements.

To be eligible for the BCCM program, a woman must be under age 65. (The BCC Screening program, coordinated by DHS Health Services, has its own eligibility criteria for screening services which includes a requirement that the woman be at least 40 years old.)

OHP child in school 461-001-0000; Age requirements: 461-120-0510  
Regular school attendance: 461-120-0530  
OHP-OPU, Effective Dates for the Program: 461-135-1102

### **2. Oregon Residence**

To be eligible for medical assistance, people must be residents of Oregon. They must be currently living in Oregon and intend to remain in the state. There is no requirement that they must have been in Oregon or intend to remain in the state for a minimum amount of time. Residents can leave the state for temporary purposes (e.g., vacation, school

attendance, medical treatment, employment) and keep their residency as long as they intend to return to Oregon.

A new resident receiving medical assistance from another state may receive duplicate medical assistance from Oregon, if the person would be eligible in Oregon and would not otherwise receive medical care.

Residency requirements: 461-120-0010  
Statement of intent to reside: 461-120-0050  
Duplicate benefits: 461-165-0030

### **3. Eligibility for People in Correctional Facilities**

An inmate of a public institution is not eligible for benefits. An inmate is a person living in a public institution who is:

- Confined involuntarily in a local, county, state, or federal prison, jail, detention facility, or other penal facility, including a person being held involuntarily in a detention center awaiting trial and a person serving a sentence for a criminal offense;
- Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;
- Residing involuntarily in a facility that is under governmental control; or
- Receiving care as an outpatient while residing in a public institution.

A public institution is an institution that is the responsibility of a governmental agency or over which a governmental agency exercises administrative control. Administrative control includes but is not limited to ownership and control of the physical facilities and grounds used to house inmates. A governmental agency exercises administrative control when it is responsible for the ongoing daily activities of a facility; for example, when facility staff members are government employees, or when a governmental agency, board, or officer has final authority to hire or fire employees of the institution. As used in this section, public institution relates to individuals residing in a correctional facility and not a medical facility.

Close benefits for inmates with a basic decision notice effective the last day of the month in which the notice is sent. If the inmate is released prior to the effective date for closure, and DHS is notified of the release prior to the effective date, restore medical benefits.

An individual is no longer an inmate when:

- The person is released on parole or probation;

- The person is on home- or work-release, unless the person is required to report to a public institution for an overnight stay; or
- The person is staying voluntarily in a detention center, jail, or county penal facility after his or her case has been adjudicated and other living arrangements are being made for the individual.

Eligibility for Inmates: 461-135-0950  
Notice Situation, Nonstandard Living Situations: 461-175-0230

#### **4. Incarcerated Pregnant Women Receiving Medical Assistance**

An inmate as described in section 3 above is not eligible for benefits. However, a pregnant woman determined eligible for medical assistance is assumed eligible for medical assistance through the date her pregnancy ends.

If a pregnant woman receiving medical assistance becomes an inmate of a public institution, her medical benefits are suspended. However, her medical eligibility continues as an assumed eligible pregnant woman. Upon notification the pregnant woman has been released, her medical benefits are restored without an application if she continues to reside in Oregon.

To suspend medical benefits for a pregnant woman who becomes an inmate of a public institution:

- Create a separate medical case for the pregnant woman if she is not already on her own case.
- Use the “SUSM” incoming code to suspend medical benefits. The case will remain in suspense status for six months before the case is auto-closed showing a “SUSPCL” incoming code.
- Use the “IN” reason code and “IN” notice code. The notice code will initiate the “IN” CMS notice (Pregnant female benefits suspended – Incarceration).
- Add the “INM” case descriptor to the case.

To restore the pregnant woman’s medical benefits upon notification she is no longer an inmate of a public institution:

- Start medical eligibility effective the first day she is no longer an inmate of a public institution.
- Remove the “INM” case descriptor from the case.

- If her eligibility period has already passed, complete a *Request for Medical Eligibility* (AFS 148) form and submit it to Client Maintenance Unit.

When An Application Must Be Filed: 461-115-0050  
Assumed Eligibility: 461-135-0010  
Eligibility for Inmates: 461-135-0950

## 5. Citizen/Alien Status

### Citizenship Documentation Requirements

The Deficit Reduction Act (DRA) of 2005 requires documentation of U.S. citizenship and identity in the case record for certain medical clients. Some clients are not affected by the documentation requirements in the Deficit Reduction Act:

- Noncitizens.
- CHIP children.
- Pregnant and post partum women who are assumed eligible for Medicaid (new applicants who are pregnant are not assumed eligible).

Some Medicaid clients are considered to have met the U.S. citizenship documentation requirements already and do not need to provide evidence of citizenship:

- SSI recipients.
- Medicare recipients.
- SSDI recipients.
- Assumed eligible newborns born in Oregon. Once determined to be an assumed eligible newborn born July 1, 2006, or later, the client is exempt from providing citizenship documentation. A new system code to track Oregon born AENs has been requested.

### Application Processing

The CHIP Reauthorization Act of 2009 revised the citizenship documentation requirements. Effective April 1, 2009, Medicaid applicants need no longer provide citizenship documentation before their benefits can be opened for the first time.

Instead of waiting for the citizenship documentation, if the applicant is otherwise eligible for Medicaid, open their Medicaid benefits and pend for the citizenship documentation.

- For new applicants, pend for citizenship documentation for 45 days from the date of request. Remember, do not delay medical benefits to an otherwise eligible applicant who has been pended for citizenship documentation for the first time.

- If an applicant or recipient can get the documentation, but needs extra time, it is possible to authorize an extension of the 45-day pend period, but be very careful to provide a new pend notice with a new date and to track progress. Determine what new pend date to use by jointly determining with the client the length of time you both believe will be necessary.
- If the client is required to provide citizenship documentation and does not provide the necessary documentation within the time allowed, and does not request an extension, medical benefits must be closed with a timely continuing benefit notice.

### **Implementing the April 1, 2009, Policy Change**

The CHIP Reauthorization Act of 2009 revised the DRA citizenship documentation requirements.

If the date of request (DOR) is on or after April 1, 2009, and the only eligibility item remaining is citizenship documentation:

- Open the Medicaid and pend for citizenship documentation. If the client has already been pended, you will need to resend a pend notice so the client will not think all eligibility criteria has been met when they get the approval notice.
- Add each pended recipient with the CIP need/resource item. Each recipient is provided a ‘reasonable opportunity period’; a minimum of 45 days plus time for a 10-day closure notice to provide the pended citizenship documentation. If the recipient requests an extension, or if the eligibility worker has ordered a birth certificate and it has not arrived, the reasonable opportunity period can be extended.
- Each time the reasonable opportunity period is extended, staff must send a new pend notice which includes the new documentation due date, and narrate the action in TRACS. Be sure to change the CIP to CIE and add a new CIE end date. Once the documentation is received, staff should update the Person Alias/Update screen citizenship fields and narrate in TRACS.
- If the documentation is not received in the reasonable opportunity period and the client does not respond to the pend notice, a closure notice will be automatically sent, the CM system will automatically change the CIP/CIE case descriptor to CID and end Medicaid benefits. No further action will be required by the eligibility staff.
- If the benefits for a recipient are closed because they did not provide the citizenship documentation within the time frame allowed, and they reapply after benefits are closed, determine if the individual had good cause for not requesting an extension. If there was good cause, restore the medical, code with CIE, and repond, extending the due date. Narrate in TRACS. If there was no good cause, pend for the documentation, but do not open medical while pending for the citizenship documentation.

If the DOR is prior to April 1, 2009, and the application is currently pending, and the applicant is otherwise eligible for a Medicaid program (the only item pended for is citizenship documentation):

- Open the Medicaid effective April 1, 2009. Resend a pend notice so the client will not think all eligibility requirements have been met when they get the approval notice. Once the pended recipient provides the citizenship documentation, send a 148 to retro medical back to the date of request.
- If all other eligibility criteria has been met but the applicant has not provided the citizenship documentation, open the Medicaid assistance. Review the CIP coding and, if necessary, repond for citizenship documentation and update the CIP to CIE with a new end date.
- If an applicant has been pended for citizenship documentation and other verifications, remove the CIP/CIE coding. These individuals cannot be opened while pending for citizenship documentation because other verification is also necessary to determine eligibility.

#### **Examples:**

*Example 1: Jane is receiving CHP benefits with her mother, Ann Doe. Ann lost her job and applied for TANF/MAA on April 15. Jane and Ann's citizenship documentation is the only item remaining before MAA can be opened. Convert Jane and Ann to MAA and add the CIP coding for 06/09 to both Jane and Ann.*

*Example 2: Bill applied for OHP for his two children on March 15. The children are eligible for OHP except that Bill lost his children's citizenship documentation from California. Open the children's OHP-OPC medical effective April 1 (the date the new policy was effective), add the CIP coding to each child, and add OPC need/resource items with end date of 03/2010. Once the citizenship documentation is provided, send a 148 to add the children's medical from March 15 through March 31. In this example, the certification is 12 months. Following current policy, the initial prorated month does not count toward the 12-month certification.*

*Example 3: Frank applied for OHP for his two children February 15. The children are eligible for OHP except for citizenship documentation. Open the OHP-OPC medical effective April 1, add the CIP coding to each child, and add the OHP need/resource items with an end date of 02/2010. In this example, consider March the first month when determining the 12-month certification. The initial prorated month does not count toward the 12 month certification, but March does count.*

**Note:** *If the benefits for a recipient are closed because they did not provide the citizenship documentation within the time frame allowed, and they reapply after benefits are closed, determine if the individual had good cause for not requesting an extension. If there was good cause, restore the medical, code with CIE, and repond, extending the due date. Narrate in TRACS. If there was no good cause, pend for the documentation, but do not open medical while pending for the citizenship documentation.*

### **Recording Documentation**

The DRA also requires the case record contain documentation to support the declaration of citizenship. DHS staff must view original documents or certified copies from the issuing agency.

You may be provided documentation by mail or in person. If mailed, place a copy in the case record and return original documents via regular mail.

You may also be provided documentation from contracted outreach facilities. Outreach facilities can attest they have viewed the original citizenship and identity documents. They use the *U.S. Citizenship and Identity Proof Documentation* (OHP 7203) form to verify which documents they have viewed. We can accept the OHP 7203 when it is date-stamped by the outreach center and bears the outreach facility identification code.

- DHS has made a commitment that there will be “no wrong door” for applicants and recipients who are providing documents. If an individual brings original documents to any DHS office or branch, even when the client’s case is in another branch, the following steps must be taken:
  - Accept whatever original documents or certified copies from issuing agencies the client brings in.
  - Copy and return the original documents to the client.
  - Date stamp the copies, make a note on them that we have viewed the original documents (some branches have a date stamp that already says this) and sign or initial.
  - Some branches review the documents provided, and if the documents meet the requirements of citizenship and identity for this provision, they update the CI Person/Alias Update screen before they send the copies to the appropriate branch. This is a decision that can be made on the branch level.
  - Narrate in TRACS that the client brought in documentation, state what the documentation was and what branch it is being sent to, if it is going to another branch.
  - If an individual provides fraudulent citizenship related documentation, we are required to report it to the agency that issued the document. For

example, if a fraudulent birth certificate is submitted, notify the issuing state's vital records agency.

Once documented, we should not need to verify a client's U.S. citizenship status again. The expectation is that the citizenship field on Person/Alias Update will be a key tool in tracking citizenship documentation. If you look on Person/Alias Update and the citizenship field indicates acceptable verification has been provided, you do not need to reverify citizenship.

Copies of the accepted documents should be included in the case record. We can photocopy passports and other documents marked "Do not copy" for our files.

The case record includes:

- Imaged documents.
- Case file.
- Updated citizenship field on the client's Person/Alias Update screen Citizenship Field.

The Person/Alias Update citizenship field must be updated to reflect citizenship status. All reports, audits, and other reviews will use the citizenship field.

### **Acceptable Documentation**

States are required to use the most reliable form of documentation available. A hierarchical list has been provided.

☞ SEE WORKER GUIDE MA-3: CITIZENSHIP AND IDENTITY DOCUMENTATION HIERARCHICAL LIST FOR THE COMPLETE HIERARCHICAL CITIZENSHIP DOCUMENTATION LIST.

- "Primary documents" from the hierarchical list are considered the most reliable and may be used to document both citizenship and identity.
- However, we can accept secondary documentation if primary documentation is available within 45 days, but secondary is already available. We can also accept secondary level documentation if a client has a passport but they do not have immediate access to it or their birth information is on BBCN.
- If it is determined that the client cannot obtain a higher level citizenship documentation within 45 days from the DOR, accept lower level documentation. Do not pend for higher level documentation.
- If the applicant or recipient needs to order birth certificates from out of state, provide the list or the link to state vital records contacts at:  
[www.cdc.gov/nchs/howto/w2w/w2welcom.htm](http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm)

☞ SEE FSM MULTIPLE PROGRAM WORKER GUIDE MP-3, VITAL STATISTICS, FOR A LIST OF OUT-OF-STATE VITAL RECORDS CONTACTS.

### **Hardship Criteria**

In certain limited circumstances, we may be able to help assist with payments for citizenship documentation until June 30, 2009.

*Note: DHS will re-evaluate this policy on an annual basis.*

Pay via the *Authorization of Cash Payment* (DHS 437) using pay reason 30 or SPOTS object code 6913 (**do not** use code 6912). We can pay when the individual is unable to pay for the required documentation due to:

- Gross income is at or below 10 percent of the federal poverty level (FPL); or
- Liquid resources are less than \$100; or
- When income, less shelter and utilities, is less than 10 percent FPL; or
- When the client is homeless; or
- When there is domestic violence.

In circumstances where the individual meets one of these hardships, but has a resource to pay the cost of documentation, we will allow them to pay for the documents. We will not purchase driver's licenses in place of state I.D. We will not pay for passports or naturalization papers except in very rare circumstances. Consult a Medical Program Analyst before paying for passports or naturalization papers.

Payments cannot be made to reimburse the applicant or recipient.

To order a birth certificate for clients meeting the hardship criteria:

- Go to the CDC "Where to Write for Vital Records" website at: <http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm>. The website has links to each state's vital records for birth certificate requests.
- Follow the state's instructions for ordering a birth certificate and complete the required letter or form. The requirements vary by state; for example, some states require the client or the client's parent sign a statement authorizing the request for a birth certificate.
- Mail the required letter or form requesting the birth certificate. Enclose a pay reason 30 revolving-fund check in the requirement amount.

## **Oregon's Vital Records Screens**

Access to Vital Records screens is limited to viewing. **NEVER PRINT VITAL RECORDS SCREENS!** Narration and updating citizenship documentation fields on the Person/Alias Update screen fully meets the documentation requirements.

We have been given access to screens that provide birth, marriage, and divorce data.

The birth screens are:

BBCN Browse by child's name

- The mother's birthplace listed on BBCN is self-disclosed and does not meet documentation requirements.

BBMN Browse by mother's name

You may need to confirm name changes to verify identity. Vital records has also provided access to marriage and divorce screens:

For marriage:

BMBW Browse by bride

BMBH Browse by groom

BMBD Browse by date of marriage

For divorce:

BABW Browse by wife

BABH Browse by husband

BABD Browse by date

We have also been given access rights to death data:

BDBN Browse by name of deceased

BDBD Browse by date of death and county

☞ SEE THE COMPUTER GUIDE CHAPTER XIII(C) FOR MORE INFORMATION ABOUT THE VITAL RECORDS SCREENS.

## **The Citizenship Field on the Person/Alias Update Screen**

- To access the Citizenship field on Person/Alias Update, go to the client's CI-FIND screen. Press F16.

There are three fields that are used to support citizenship. The first field is the "Cit" field. The Cit field indicates if client has met Medicaid required documentation of citizenship, including identification requirement:

An “A” in the Cit field means that the client has provided “Acceptable documentation” and has met the DRA requirements. The client has declared U.S. citizenship and provided Medicaid approved documentation of citizenship and identification.

A “D” in the Cit field means the client has declared U.S. citizenship but has not yet provided documentation.

An “X” in the Cit field means the client has not requested Medicaid or that no information is available.

An “N” in the Cit field means noncitizen who meets Medicaid/SCHIP alien status requirements, i.e., is eligible for full medical benefits (is not limited to CAWEM). A documentation source code is not allowed for persons with an “N” in the Cit field.

*Note: Do not code a Refugee with an “N.”*

A “C” in the Cit field means noncitizen who has not yet met the Medicaid/SCHIP alien status requirements (if otherwise meets medical program requirements may receive CAWEM benefit package). A document source code is not allowed for persons with a “C” in the Cit field.

The “V/R” field indicates whether the documentation has been reported but not verified or verified per the DRA requirements. A “V” means both citizenship and identity meet DRA requirements.

The next field identifies what source was used to report or verify citizenship and identity. For example, “PS” is the code for passport; “BP” is the code for public birth record and includes Vital Records screen verification such as BBCN.

To update the citizenship fields on Person/Alias Update:

- Tab to the bullet to the left of the “Cit” field. Enter an X on the bullet. Press F13. The Citizenship Update screen will display.
- Enter the appropriate codes in the Cit, V/R, and Src fields. Press F9 to save.
- F3 will return you to Person/Alias Update.

### **Alien Requirements Overview**

To determine if an applicant meets the alien status requirements (except CAWEM), see section C.1 of the Noncitizens Chapter (NC C.1).

CAWEM applicants are not required to declare or provide proof of their citizenship or immigration status. Nonapplicants do not have to meet the citizenship or alien status requirement. Nonapplicants are not required to declare or provide proof of their

citizenship or immigration status. The disclosure of information regarding citizenship and alien status for nonapplicants is voluntary.

**Note:** *Nonapplicants are persons who choose not to apply for benefits or who are not eligible to receive benefits, even though they may be required to provide verification of income and resources.*

To be eligible for the CAWEM program, a client must be ineligible for MAA, MAF, OHP, or OSIPM solely because they do not meet citizenship or alien status requirements. See section C.3. of the Noncitizens Chapter (NC C.3).

☞ SEE THE NONCITIZEN CHART IN THE MULTIPLE PROGRAMS WORKER GUIDE CHAPTER FOR MORE INFORMATION.

Citizen/Alien Status Requirements: 461-120-0110  
 Alien Status; Not REF or REFM: 461-120-0125  
 Declaration of Citizenship or Alien Status: 461-120-0130  
 Application Processing Timeframes; Not Assessment, FS or TA-DVS: 461-115-0190  
 Required Verification; OHP: 461-115-0705  
 Assumed Eligibility for Medical Programs: 461-135-0010

## 6. Social Security Number

To be eligible for medical benefits, all applicants (except assumed eligible newborns and CAWEM applicants) must provide a Social Security number (SSN) or verify they have applied for one as a condition of eligibility.

Applicants who do not have to meet the SSN requirement include:

- A newborn is assumed eligible for medical benefits for up to one year.
- CAWEM applicants.

Nonapplicants do not have to meet the SSN requirement. It is only on a voluntary basis that a nonapplicant provide their SSN. Nonapplicants are persons who choose not to apply for benefits or who are not eligible to receive benefits, even though they may be required to provide verification of income and resources.

If an applicant has not been issued a SSN, assist the applicant in applying for a SSN. If an applicant does not recall their SSN, assist the client in verifying the number.

☞ SEE MULTIPLE PROGRAM WORKER GUIDE #2, VERIFYING CLIENT INFORMATION.

Do not deny or delay medical benefits to an otherwise eligible applicant pending the issuance or verification of an individual's SSN. However, if an applicant required to meet

the SSN requirement refuses to apply for or provide an SSN, the applicant is not eligible for benefits.

Requirement to Provide or Apply for SSN: 461-120-0210

## 7. Pursuing Assets

To be eligible for medical assistance, people must actively pursue assets for which they have a legal right or claim, i.e., unemployment compensation, workers compensation, Social Security Benefits, or any third party which may be liable for payments. However, people applying for one of the department's programs are not required to apply for other programs it administers. People eligible for MAA, MAF, SAC, or EXT are not required to pursue SSI benefits.

To pursue assets, they must apply for and satisfy all requirements to receive benefits from other programs. They must also pursue legal remedies to obtain assets from any other source if they can secure legal counsel on a contingency fee basis. People do not have to pursue loans.

People without good cause who do not pursue assets they may be entitled to are not eligible for medical assistance. This ineligibility ends when they provide evidence that they are willing to cooperate. Only the individual who can pursue the asset is assessed the penalty and loses medical eligibility. Other individuals in the benefit group, such as other adults or children, continue to receive medical assistance.

For example: Unless there is good cause not to pursue, clients who have been in a car accident must help pursue third-party coverage. Clients may be pended for *Vehicle-Related Personal Injury* (DHS 451) or *Non-Vehicle-Related Personal Injury* (DHS 451NV) forms.

### Pursuing UC

One key asset is unemployment compensation (UC). Most clients applying for or receiving EXT, MAA, MAF, OPC, CHP, OPP and OPU and SAC are required to pursue UC if it could be an available asset.

☞ SEE TANF E.7 FOR INFORMATION ABOUT MAA/MAF PWE APPLICANTS AND THE REQUIREMENT TO APPLY FOR UC TO MEET DEPRIVATION REQUIREMENTS.

As with other assets, pursuing UC means applying for UC and, if eligible, meeting the Employment Department work search (or other) requirements. If an individual does not have good cause not to pursue UC, that person is not eligible for SSP medical program benefits.

### **Pregnant women and pursuit of UC**

- Unless the pregnant woman has good cause not to apply or is receiving TANF and determined to be JOBS exempt, require pregnant women at initial MAA application (not yet receiving Medicaid benefits) to pursue UC.
- Unless there is good cause, MAF and OHP pregnant women are also required to apply for UC.
- Once the pregnant woman's Medicaid benefits have begun, she has protected eligibility. Do not require ongoing pregnant Medicaid recipients to pursue UC as part of their eligibility for Medicaid. Once a pregnant woman is receiving Medicaid, she cannot be penalized for refusing to pursue UC.

### **Applicants**

- MAA and MAF applicants may notify you they will not apply for UC. If an MAA or MAF applicant lets you know they choose not to apply for UC, determine if the client has good cause for not applying. If they do not have good cause, deny just the applicant who refuses to apply. Do not deny anyone else in the filing group such as the children or second parent.
- If you have pended the MAA or MAF applicant to pursue UC and the applicant does not respond to the pend notice (does not contact you about the UC requirement during the pend period), the entire filing group is denied assistance. You can let the CM system deny everyone on the application for failure to complete the application process ("DD" or "AP" denials). ***The denial is not for failure to pursue UC, but because the client did not complete the application process.***
- For OHP, if the adults are not applying for OHP for themselves or if they are applying for OHP-OPU and ineligible because they are new applicants, do not pend the adults for pursuit of UC.

### **Recipients**

When pending a client at redetermination, add the BED coding and send the pend notice to require the client to pursue UC.

- If there is more than just UC pended and the client does not respond to the redetermination pend notice, let the CM system send the 77B BED close notice and end benefits for everyone in the household for failure to complete the redetermination process. The CM system will not end benefits for clients who have protected eligibility, such as AENs or women still in their protected eligibility period. ***The closure is not for failure to pursue UC, but because the client did not complete the redetermination process.***

- For OHP only, if there is an ongoing OHP-OPU client and the only item to pend is UC, recertify everyone else in the household. Pend the ongoing OHP-OPU client for UC and add the BED coding. Do not update the STD need/resource end date.

If the client pended for pursuit of UC does not respond to the pend notice, the CM system will send the 77B BED close notice and end benefits. CM will end benefits only for the person(s) whose medical was not recertified. It will not end medical for pregnant women or AENs.

*If there is no ongoing OHP-OPU client, do not pend the adults for UC.*

For EXT, MAA, MAF and OHP at redetermination/recertification, if a recipient notifies you that they choose not to apply for UC, determine if the client has good cause for not pursuing. If no good cause:

- Send a 10-day close notice and the DHS 462A and end the recipient's medical benefits. Do not end the benefits for anyone else on the case because the recipient refused to apply for UC. If the recipient is pregnant, do not require her to pursue UC as part of her medical redetermination.

For ongoing medically eligible clients not at redetermination:

- If an ongoing EXT, MAA or MAF client reports a change that indicates they might be eligible for UC, pend the client for UC, unless pregnant. If they do not respond, send a 10-day notice and DHS 462A and end their benefits.

### **Good Cause**

For EXT, MAA, MAF and OHP if the client has been pended for pursuit of UC and contacts the department within the 45-day pend period with concerns about applying for UC, consider if the client has good cause for not pursuing UC before denying or ending benefits.

- To qualify as good cause, there must be a circumstance beyond the client's control for not pursuing.
- For example, pregnant applicants are not automatically exempt from pursuing UC unless also in JOBS and determined to be JOBS exempt. However, a pregnant client with health concerns may have good cause not to pursue UC.
- For example, attending college is not sufficient good cause. However, a teen parent in high school through the JOBS program may have good cause not to pursue UC.

**Note:** *The pursuit of UC policy applies to SAC children who are receiving behavioral rehabilitation services (BRS) and psychiatric residential treatment services (PRTS); however, BRS and PRTS children always have good cause not to apply for UC. (SAC cases are carried by the Children's Medical Project Team at the OHP Statewide Processing Center.)*

## Frequently asked questions and answers

**Question 1:** For DV applicants, can we open medical without having them apply for UC?

*Answer 1: Yes, you can give them good cause not to apply if it appears they are not available to look for work because of DV issues.*

**Question 2:** I have an MAA/TANF client in JOBS. She is attending high school and you are telling me she has to apply for UC?

*Answer 2: JOBS exempt clients do not have to pursue UC (it is in rule 461-120-0330). Technically, mandatory JOBS clients need to pursue UC, but I can see why you would not want a teen parent to have to do so as part of her medical eligibility. You can give her good cause for not applying for UC if it would interfere with her JOBS plan. Remember to narrate your decision. (It could turn out to be a QC error if you do not narrate it.)*

**Question 3:** Why do we need to pend an OHP client for UC? It does not matter for them because it can not be a part of the three-month income average.

*Answer 3: At field request and to streamline eligibility, we are no longer requiring OHP clients who are not eligible for benefits or not applying for benefits to apply for UC.*

**Question 4:** What if my client tells me he is not going to pursue UC?

*Answer 4: If he is a new MAA/MAF applicant and refuses to apply for UC, we do not need to pend him for pursuit, but we do have to consider whether he must be denied MAA or MAF. First, consider if he has good cause. If he does not have good cause for refusing to apply for UC, deny just him (just the person who refuses to apply for UC) and open the children and the second parent on the case, if there is one. (The penalty for failure to apply for UC only applies to the person that does not apply for UC). Send him a denial notice explaining the UC issue and a DHS 462A. The person who refused to pursue UC is still in the need group; his income and resources still affect the family's eligibility.*

*If he is an ongoing MAA/MAF client at redetermination and he refuses to apply, send him a close notice and a DHS 462A and continue the review process for the rest of the family. Let him know he can change his mind, pursue UC and get back on MAA/MAF at any time.*

**Question 5:** My MAA client is pregnant. Does she need to pursue UC?

*Answer 5: Yes, she does at initial application (unless she is exempt from JOBS participation. JOBS-exempt clients do not have to pursue UC). If she has health concerns or is unable to look for work, you can give her good cause not to apply for UC, but for medical only clients, it is usually better to have clients apply for UC and let the*

*Employment Department make a decision about whether the client is available to look for work. The good news is it is a prudent person (common sense) decision, so you can pretty much do what you want as long as it makes sense and you narrate it. If you are not sure, ask your lead or a policy analyst.*

*Do not pend pregnant clients already receiving Medicaid to apply for UC. Technically, they are required to pursue UC, but since they have protected eligibility status, we cannot end their benefits because they refused to apply for UC. Rather than create extra workload, the policy decision is not to require pregnant recipients to apply for UC.*

**Question 6:** Why make MAA/MAF clients apply for UC if their WBA (weekly benefit amount) will not affect their medical anyway?

*Answer 6: We called an Employment Department trainer about WBAs. The trainer said that WBA calculations expire and that we cannot know for sure what the current WBA amount is. It is better to have the client apply, let the Employment Department figure it all out and then make a decision.*

**Question 7:** My MAA client is working part time and I know he is not eligible for UC because his earnings are over the WBA amount. I do not need to make him apply, do I?

*Answer 7: Yes, have him apply for UC. Let the Employment Department make the decision. There are lots of ins and outs about UC that we do not know (just like they do not know all our rules).*

**Question 8:** My MAF client is a college student. He did not quit a job to go to school but since he is in school I know he can not get UC. Why make him jump through hoops and apply for UC just to be denied?

*Answer 8: We called an Employment Department trainer about this issue. The trainer said that the Employment Department does not automatically deny UC just because the UC applicant is a student. He needs to apply for UC. If he refuses, deny his medical with a denial notice and DHS 462A and open for the rest of the family.*

**Question 9:** My MAA client quit work to go to school. Do I still need to make him apply for UC?

*Answer 9: Yes. For EXT, MAA, MAF and OHP clients, quitting a job does not automatically make the client ineligible for UC. If he refuses to apply for UC, he will no longer be eligible for CAF SSP medical. Send a 10-day close notice and a DHS 462A and end his medical benefits. Narrate your decision.*

**Question 10:** My MAA client applied for UC and I opened the case, but then he did not follow up on the UC.

**Answer 10:** *If he does not have good cause, send a 10-day close notice and a DHS 462A and end his benefits.*

**Note:** *Frequently, there is a time lag from the time the client initially applies for UC and the time the medical is opened. Before opening, check on the UC screens to see if the client is actually pursuing the UC. If not, then determine if the client has good cause. If no good cause, deny just the person who did not pursue U.C.*

**Question 11:** What if my MAA client does not want to look for work right now?

**Answer 11:** *This is a single-parent MAA only client (not JOBS exempt)? If so, unless she has good cause for not looking for work, send her a pend notice. If she does not start pursuing UC, send a 10-day notice of reduction and DHS 462A and end her medical. (Do not end medical for anyone else in the filing group.)*

**Question 12:** My MAA CWM client just lost his job. Do I need to pend him for UC?

**Answer 12:** *Yes, but only if he could be eligible for UC. Do not pend if UC is not an available asset. For example, if he is using someone else's SSN or does not have a work permit, it is not an available asset and there is no reason to pend him. Narrate why you did not require him to apply.*

Availability of Income: 461-140-0040  
Requirement to pursue assets: 461-120-0330  
Personal Injury Claim: 461-195-0303

## **8. Pursuing Assets; Health Care Coverage and Cash Medical Support**

To be eligible for medical assistance, most people must pursue available health care coverage or cash medical support for members of the benefit group. Requirements vary by program, depending upon whether the asset is health care coverage or cash medical support.

### **Health Care Coverage Cooperation**

Cooperation in pursuing health care coverage includes, but is not limited to, applying for, accepting, and maintaining all available cost-effective health care coverage, and identifying and providing information to the department in obtaining health care benefits.

**Medicare:** Adult clients must make a good-faith effort to obtain coverage under Medicare.

**Pursuing claims for damages:** Adults must pursue a claim for damages from personal injuries, including the completion of the *Vehicle Related Personal Injury* (DHS 451) and *Non-Vehicle Related Personal Injury* (DHS 451NV) personal injury forms.

**Employee-sponsored health care coverage:** Cooperation with health care coverage means that persons (except for pregnant women, OHP-CHP-eligible individuals, OHP-OPU-eligible individuals and persons excused for good cause) eligible for medical assistance are required to:

- Apply for, accept, and maintain cost-effective, employer-sponsored health insurance.

Insurance is considered cost-effective when the employee's share of the premium is equal to or less than the Cost-Effective Health Insurance premiums (HIP) standard. If the insurance is not cost-effective, the person cannot be required to apply for or accept the insurance. See Specific Eligibility Requirements, section E of this chapter (MA E.) for more information about obtaining employer-sponsored, cost-effective health insurance.

**OHP-OPU clients:** Cooperation with health care coverage includes the requirement that OHP-OPU clients cooperate with the FHIAP application process. In the OHP-OPU program, a person (except for American Indians/Alaska Natives; persons eligible for Indian Health benefits; and persons eligible under CAWEM) who has group health insurance available (but is not enrolled) through an employer is required to:

- Cooperate in determining eligibility for the Family Health Insurance Assistance Program (FHIAP). Under FHIAP, a person receives a monthly subsidy to cover a portion of the person's health insurance premiums.
- If eligible for FHIAP, the person must apply for and accept the health insurance and enroll all OHP-OPU recipients on the case who are eligible for the insurance.

Eligibility under the OHP-OPU program ends and the person receives assistance for the health insurance premiums under FHIAP. If not eligible for FHIAP, the person is not required to enroll in their employer's insurance and, if otherwise eligible, continues to receive benefits under the OHP-OPU program.

**Cash medical support:** Cash medical support is cash ordered to aid the custodial caretaker in meeting medical needs for the child. Cash medical support is part of the requirement to cooperate with the Division of Child Support and is included in the "Cooperation with the Division of Child Support" subsection below.

### **Cooperation with the Division of Child Support**

Applicants for Medicaid assistance are required to agree to cooperate with the Division of Child Support to obtain health care coverage or cash medical support through a noncustodial parent unless they have good cause not to cooperate.

Exceptions to the requirement to cooperate with the Division of Child Support:

- Parents of OHP-CHP children are not required to cooperate with the Division of Child Support.
- Pregnant women are excused from cooperating with the Division of Child Support.
- Persons with good cause not to cooperate with the Division of Child Support (see the Good Cause subsection below).

Most Medicaid clients cannot be required by the department to complete paternity affidavits or pursue health care coverage or cash medical support at initial application or at redetermination of Medicaid eligibility. Signing the application is proof the client has agreed to cooperate. However, if the Division of Child Support sanctions an adult applicant for failure to cooperate during the application process, the adult applicant who failed to cooperate is denied. Use the CSM case descriptor to identify applicants denied for failure to cooperate.

What cooperation with the Division of Child Support includes:

Medical program recipients (except OHP-CHP clients, pregnant women, and persons excused for good cause) are required to:

- Assist the department and the Department of Justice, Division of Child Support in establishing paternity for a child and obtaining health care coverage and cash medical support.
- Assign cash medical support payments to the department. Once Medicaid coverage for a child receiving cash medical support begins, the Division of Child Support will send the cash medical support payment to DMAP.

☞ SEE THE CHILD SUPPORT CHAPTER FOR INFORMATION ON THE ASSIGNMENT PROCESS AND HOW TO IDENTIFY THE CASH MEDICAL SUPPORT PAYMENT

Applying the penalty for noncooperation with health care coverage and cash medical support:

Adults who do not cooperate and do not have good cause, are not eligible for medical assistance. There is no ineligibility for pregnant females who refuse to cooperate.

**Note:** *Medical-only clients may be disqualified for failure to pursue a cash medical support order. They cannot be disqualified for failure to pursue cash support not specifically dedicated to medical expenses.*

Additionally, only the individual who can legally assign rights and obtain the insurance is assessed the penalty for failure to meet this requirement, or in other words, loses medical eligibility. The other individuals in the group, such as other adults and children, continue to receive Medicaid.

Ineligibility for medical assistance ends when the person provides evidence that they are willing to cooperate.

Good cause for not cooperating with the Division of Child Support:

A person is excused for good cause from the requirement to obtain health care coverage or cash medical support from the Division of Child Support if:

- Cooperation would result in emotional or physical harm to the dependent child or to the person. The person's statement alone is sufficient evidence that harm would result. Additional evidence is not necessary to grant good cause.
- Continuing efforts to establish paternity or obtain medical support would be detrimental to the dependent child because the child was conceived as a result of rape or incest. The person's statement alone is sufficient evidence on the issues of conception and detrimental effect to the child. Additional evidence is not necessary to grant good cause.
- Legal proceedings are pending for the adoption of the child.
- The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption.

People who claim good cause for refusing to cooperate on grounds other than those listed above have 20 days from the date of refusal to provide the statement or evidence. If they have difficulty getting evidence, allow a reasonable time to provide the information. Consider them to have good cause if they have made a good-faith effort to provide verification but are unable to do so.

Medical assignment: 461-120-0315  
Requirement to pursue assets: 461-120-0330  
Clients Required to Obtain Health Care Coverage and Cash Medical Support: 461-120-0345  
Medical cooperation: 461-120-0345  
Good cause for failure to cooperate: 461-120-0350  
Personal Injury Claim: 461-195-0303

## 9. FHIAP Referral Process; OHP-OPU Program

To be eligible for the OHP-OPU program, a person must not be covered by private major medical health insurance and must not have been covered by private major medical health insurance during the six months preceding the effective date for starting OHP medical benefits.

☞ SEE MEDICAL ASSISTANCE CHAPTER E.8, FOR MORE INFORMATION REGARDING SPECIFIC PROGRAM REQUIREMENTS FOR OHP-OPU.

An OHP-OPU applicant who has access to (but is not enrolled in) group health insurance available through his or her employer must cooperate in determining eligibility for the

Family Health Insurance Assistance Program (FHIAP). Exempt from this requirement are OHP-OPU clients who are American Indians/Alaska Natives, persons eligible for Indian Health benefits and for persons eligible under CAWEM.

For an OHP-OPU applicant to complete the application process, the Group Insurance Information form (442-091) is required. Once the application process is completed, medical assistance eligibility is determined.

If eligible:

- Certify OHP medical benefits.
- Make a referral to FHIAP for the OHP-OPU eligible person by mailing the Group Insurance Information form (442-091) along with a copy of the medical assistance application to:

FHIAP  
PO Box 5880  
Salem, OR 97304-0880

When a person receiving benefits under the OHP-OPU program reports he or she has access to (but not enrolled in) group health insurance available through his or her employer, the person needs to have the Group Insurance Information form (442-091) completed by the employer and returned. A referral is made for the person by simply mailing the Group Insurance Information form to FHIAP.

The referral will be processed by FHIAP to determine if the OHP-OPU person is eligible for a subsidy under that program. If eligible for FHIAP, the OHP-OPU person must apply for and accept the health insurance.

FHIAP staff will notify the OHP-OPU client and the OHP-OPU client's eligibility worker of the FHIAP eligibility determination:

- If FHIAP eligible, FHIAP staff will notify the OHP-OPU client's eligibility worker when a subsidy will start. The eligibility worker will end OHP-OPU benefits, send a decision notice, and narrate the information on TRACS.
- If not FHIAP eligible, FHIAP staff will notify the OHP-OPU client's eligibility worker and the person of the reason for the FHIAP denial.

A person eligible under a medical assistance program other than OHP-OPU can choose to receive benefits under FHIAP, if eligible for that program. However, a person cannot receive benefits from both programs. Clients should be advised to notify FHIAP that they have applied for DHS medical. Clients who receive FHIAP and DHS medical concurrently may incur a FHIAP overpayment.

Clients Required to Obtain Medical Coverage: 461-120-0345  
Specific Program Requirements; OHP: 461-135-1100  
Concurrent and Duplicate Program Benefits: 461-165-0030

## **Worker Guide**

### **Citizenship and Identity Documentation Hierarchical List**

- Clients should not need to verify citizenship more than once. Before requesting documentation, check the Medicaid applicant or recipient's citizenship field on Person/Alias Update. If the person's citizenship field already has an "A" and you have no reason to doubt the "A" is accurate, narrate the citizenship documentation has already been verified.
- Accept secondary documentation if primary is available within 45 days but secondary is already available. For example, for persons born in Oregon, secondary documentation is already available via BBCN. Do not pend for primary.
- If it is determined that the client cannot obtain a higher-level citizenship documentation within 45 days from the DOR, accept lower level documentation. Do not pend for higher-level documentation.
- Citizenship (including identity) documents may be expired and still be used for documentation. Use prudent person; if you cannot tell it is the same person, pend for other documentation.
- The client must provide an original or certified copy of the documentation. The local DHS office must maintain a copy of the documentation in the case record except for BBCN. Do not print BBCN screens.
- If another state has already verified citizenship and identity of an applicant per federal requirements, accept the copies of verification from the other state Medicaid office, narrate, and update the CI Person/Alias Update screen. If the other state is unable to send copies of the verification they used, we can take a written statement on their state letterhead or on an e-mail from the state government office.
- A document issued by a federally recognized Indian tribe, such as a tribal enrollment card or certificate of degree of Indian blood is now acceptable verification of U.S. citizenship, as long as the tribe is located within the States. We are waiting for federal guidance for tribes with international borders.
- Do not deny or delay medical benefits to an otherwise eligible applicant pending the verification of the individual's citizenship documentation. However, if a client who is required to provide citizenship documentation does not provide the necessary documentation within the time allowed, and does not request an extension, medical benefits must be closed with a timely continuing benefit notice.

**1. Citizenship Documentation Requirements**

<b>Primary Documentation</b>	
<b>Primary documents are considered the most reliable and may be used for both citizenship and identity.</b>	<b>Additional Clarifications/Examples</b>
<ul style="list-style-type: none"> <li>• U.S. passport.                             <ul style="list-style-type: none"> <li>☞ Spouses and children were sometimes included on one passport through 1980.</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>• Certificate of Naturalization (N-550 or N-570).                             <ul style="list-style-type: none"> <li>☞ The Department of Homeland Security issues the Certificates of Naturalization and the Certifications of Citizenship.</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>• Certificate of Citizenship (N-560 or N-561).                             <ul style="list-style-type: none"> <li>☞ The Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.</li> </ul> </li> </ul>	