month of application and for determining eligibility the next month. This can be done when:

- The client was given over 30 days to provide verification necessary to determine eligibility; or
- The same application is being used to deny one month and approve the next month’s benefits.

SEE EXAMPLE FOR A SITUATION WHERE NO DENIAL NOTICE IS NEEDED FOR CONCURRENT BENEFITS (SNAP B. EXAMPLES 7).

8. Interviews

An interview is required of all households applying for SNAP benefits. This interview is required as a part of the eligibility determination process for all initial applications and recertifications.

The purpose of the interview is to gather and review eligibility information and explore and resolve unclear and incomplete information. The person interviewed may be the head of household, spouse, any other responsible member of the filing group, or an authorized representative (SNAP B.14).

SEE SNAP WG #4 FOR IDEAS ON EFFECTIVE NARRATION

Initial application: This interview is generally conducted in the office. The interview must be conducted protecting the client’s right to privacy and confidentiality. Interview the SNAP applicant the same day they request benefits or schedule an appointment for them to return. Always give the client the appointment date and time for the interview. Also note it on the application or in narration.

The in-office interview is waived only when no authorized representative (SNAP B.14) or adult member of the filing group (SNAP C.2) can come to the office for one of the following reasons:

- All adult members of the group are over age 60, or have a physical or mental disability;
- There are transportation problems; or
- Other hardships exist. For example, illness, bad weather, work hours that conflict with the office hours, safety issues due to domestic violence, caring for a disabled member of the filing group, etc.
Note: It is not necessary to narrate the reason the in-office interview is waived. The applicant cannot be forced to do a phone interview. They may always request an in-office interview.

When the office interview is waived, a telephone interview, a home visit or an interview at a mutually agreed upon location must be conducted. The client may decline a phone interview and request an in-office interview. When this occurs, the department must grant the in-office interview.

Notification of Missed Interview

The interview appointment is scheduled for a set date and time when a client is not interviewed the same day as the filing date.

The department is required to notify all SNAP applicants that they have missed their SNAP interview appointment and that they are responsible for rescheduling the appointment. This notification must take place when the applicant misses the initial interview appointment. A second notification is not necessary if they miss more than one intake appointment during the 30-day application period. This notification is required for all SNAP benefit applicants at initial certification and at recertification.

The expectation is that the notice of missed appointment will be mailed within two business days of the missed appointment. This is to give the applicant time to receive the notice and reschedule the appointment before the 20th day following the filing date.

A Notice of Missed Interview (NOMI) is required in the following situations:

- The client leaves a filing page at the local office and is given a scheduled appointment date and time for the intake interview.

- The client is given an application to complete along with a scheduled interview appointment. They return the completed application but do not appear for the interview.

- The client receives a scheduled appointment for recertification and will complete the application when they arrive at the local office. They do not appear for the appointment and there is no filing date.

- The client receives a scheduled appointment for recertification along with an application. They do not show for the appointment or turn in the application or set a filing date.

No NOMI is required when an application is sent without an intake appointment and the client does not return the application or appear for an appointment.

To give offices a choice that will best meet their up-front process, there are two options for the notification of missed interview. These options are:
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FOR DMAP (DIVISION OF MEDICAL ASSISTANCE PROGRAMS) WORKER GUIDES, PLEASE VISIT THE DMAP WORKER GUIDES WEBSITE AT:


FOR ADULT PROGRAMS INFORMATION, PLEASE VISIT THE SPD WORKER GUIDES WEBSITE AT:

http://www.dhs.state.or.us/spd/tools/additional/workergd/index.htm
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B. Application, Redetermination, Recertification, Verification

1. Application for Medical Assistance

Application assistance programs

DMAP administers application assister programs – the Application Assistance Program, the Outreach and Enrollment Grant program and the Volunteer Organization program.

Application Assistance Program, Outreach and Enrollment Grant Program and Volunteer Organization providers work with families to help them complete the application process for their children. Neither program will work with adult only applications. Each program will stamp the application with a stamp that will include their provider number.

Each application assistance organization date stamps the application. The stamp includes their provider number.

- The Application Assistance Program provider identification stamp will always begin with “AA” followed by numbers.
- The Outreach and Enrollment Grant Program provider identification stamp will always begin with “GG” followed by numbers.
- The Volunteer Organizations provider identification stamp will always begin with “VV” followed by numbers.

CM system coding for application assistance programs

Two need/resource items are used to track families with children applying for medical and getting assistance from the Application Assistance Program. The need/resource item for the Volunteer Organization will be added soon:

- AAP (Application Assistance Program Pending) is used to track cases with an applicant under age 19 whose family is working with an Application Assistance Program provider. The AAP end date is the month/year the application would be denied or closed if the application is not completed. The need/resource provider number is the AA number stamped on the application. Do not worry about removing or changing the AAP code if the application is denied; it will drop off the case automatically.
- AAA (Application Assistance Program Approved) is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by an Application Assistance Program provider. Once approved for medical, remove the AAP need/resource code and add the AAA code. The AAA end date is the month/year the child was approved for medical. The need/resource provider number is the AA number stamped on the application. Providers will be paid $50 for each approved application, so it is important to code cases correctly.
Two need/resource items are used to track families with children applying for medical and getting assistance from the Outreach and Enrollment Grant Program:

- **GGP (Outreach and Enrollment Grant Program Pending)** is used to track cases with an applicant under age 19 whose family is working with an Outreach and Enrollment Grant Program provider. The GGP end date is the month/year the application would be denied or closed if the application is not completed. The need/resource provider number is the GG number stamped on the application. Do not remove or change the GG if the application is denied; it will drop off the case automatically.

- **GGA (Outreach and Enrollment Grant Program Approved)** is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by an Outreach and Enrollment Grant Program provider. Once approved for medical, remove the GGP need/resource code and add the GGA code. The GGA end date is the month/year the child was approved for medical. The need/resource provider number is the GG number stamped on the application. (Outreach and Enrollment Grant providers are not given a $50 payment for approved applications.)

**Application Process**

Do not require an interview for medical applicants. If the client no shows a TANF, SNAP or other nonmedical related appointment, do not deny the request for medical. Complete the medical application process through the mail and/or by phone as needed.

**Pend end dates**

The department is committed to increasing the number of children in Oregon with access to health benefits. To support Healthy Kids, we need to do everything we can to ensure families have an opportunity to clear eligibility for their children, including providing sufficient time for parents to respond to the pend notice.

- For medical programs, the client is entitled to the full 45-day pend period. Unless you are sure it will not be an issue for the family, do not pend to have eligibility items returned earlier than the 45th day.

- Sometimes 45 days is not enough. If the pend notice is sent late for a reason outside the client’s control (application temporarily lost, late processing because of workload, etc.), the original 45 days should be extended as necessary to allow for some extra time. The DOR remains the same.

- To extend the 45 days, narrate your decision and the reason it was outside the client’s control.
Applications used for SSP medical program eligibility

New medical program applicants who already have an open DHS program case do not need to complete a new application. The application may need to be amended.

Brand new medical program applicants who are not receiving any DHS program benefits must complete a new application.

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MAA, MAF. The OHP 7210, OHP 7210R, OHP 7210W or the DHS 415F may be used.

EXT. An application is not needed for EXT medical assistance.

SAC. When an application is made for SAC medical assistance, use the Application for Children in Substitute Care (DHS 1462) or the Medical Assistance Application for Children in Adoptive Care (DHS 1462A).

- All applications for SAC medical assistance are processed by the Children’s Medical Project Team at the Statewide Processing Center (5503). Children determined eligible for SAC medical assistance have their case coded at cost center 5503.

- In addition to the following, the Children’s Medical Project Team also determines eligibility for the new Chafee Medical Program for former foster care youth.

  Chafee youth are C5 children but will temporarily be placed on P2 MAA standalone cases or on the D4 program code. They will be designated by a new SCH (Special Chaffee Medical) need/resource item. Please do not transfer Chafee SCH cases out of 5503. Do not change any coding on a Chafee case.

  If you have any questions about Chafee Medical, please contact an SSP medical policy analyst by e-mail at SSP-Policy, Medical.

- DHS 1462, applications are completed by facilities on the behalf of children in substitute care. The DHS 1462 is also completed by foster care providers on the behalf of children approved for foster care in another state but who are currently residing in Oregon.

- DHS 1462A, applications are completed by adoptive parents for children subject of an adoption assistance agreement between the parents and a public agency of another state. These children are assumed eligible for SAC medical assistance.

- Completed applications can be faxed to 503-373-7493 or mailed to:

  The Children’s Medical Project Team
  Statewide Processing Center
For a child who has an immediate need for a medical ID card, please indicate “emergency application” on the fax cover sheet. Also, call the Statewide Processing Center to notify the Children’s Medical Project Team that the child’s emergency application has been faxed.

OHP. When people apply for OHP medical assistance and another program – for example, SNAP or child care – they use the DHS 415F. When applying for medical only, they may use the DHS 415F, OHP 7210, OHP 7210R or OHP 7210W.

HKC. The OHP 7210, OHP 7210R, OHP 7210W or the DHS 415F may be used.

BCCM. An application for the BCCM program is initiated only when an uninsured woman is found to need treatment for either breast or cervical cancer, or precancerous conditions, after being screened by the Oregon Breast and Cervical Cancer Program coordinated by DHS Health Services.

**Note:** If a client receiving benefits under another state’s Medicaid Breast and Cervical Cancer program is moving to Oregon and inquires about Oregon’s program, refer the client to the Oregon Breast and Cervical Cancer Program of DHS Health Services at 1-971-673-0581 (staff only) or 1-877-255-7070 (staff or clients). DHS Health Services needs direct contact with the client to determine if she meets the criteria for Oregon’s program and to coordinate treatment services, if eligible.

- The **Breast and Cervical Cancer Medical (BCCM) Program Application** (DHS 1463), form is completed by a woman who has been screened by the Oregon Breast and Cervical Cancer Program and is found to need treatment for breast or cervical cancer, or precancerous conditions. The application is provided to the woman by an Oregon Breast and Cervical Cancer Program Coordinator after the woman is diagnosed.

- The woman receives assistance in completing the application by an Oregon Breast and Cervical Cancer Program Coordinator. The Coordinator determines eligibility for BCCM and refers the application to the Statewide Processing Center.

- A woman eligible for the BCCM program will have her case coded as program P2 with a BCP case descriptor. A woman who has been screened by the Oregon Breast and Cervical Cancer Program and needs treatment but is eligible for another Medicaid program will have her case coded with that program coding and with a BCS case descriptor.

- A woman initially found eligible for BCCM may be required to complete and return an OHP 7210 or other DHS application to determine if the woman is eligible for another Medicaid program. This OHP 7210 application will be marked “BCP” on the label. If the woman submits the OHP 7210 to a branch office, it should be forwarded to the Statewide Processing Center.
SEE MEDICAL ASSISTANCE E.15 FOR MORE INFORMATION.

General Information including Authorized Representative. The application must be signed by all adult members of the filing group or their authorized representative before medical benefits may be approved. Do not pend for signatures solely to deny the medical application. When there is not an adult in the filing group or an authorized representative, e.g., a homeless child applying for benefits, the person applying must sign the application.

For two-parent households, both parents must sign the application, but if one parent is out of the home for employment, we can authorize exceptions on a case by case basis. Send exception requests to SSP-Policy, Medical.

A person or family may use an authorized representative to complete the application for them if needed. People who can be authorized representatives include a legally appointed guardian, a conservator, a person with power of attorney, a person authorized by the recipient and a person acting responsibly for the recipient. If needed, the branch may appoint a responsible person to be the authorized representative.

To designate an Authorized Representative or Alternate Payee, the client must complete the Designation of Authorized Representative or Alternate Payee (AFS 231) or the OHP Optional Assistance (OHP 7218) at application and at any time the client requests a change. If health information is to be disclosed, an Authorization for Use and Disclosure of Information (DHS 2099) is required in addition to the above mentioned forms.

The application is completed when the person completes and signs the application and provides the necessary information and verification within 45 days from the date of request. The 45-day limit may be extended when circumstances exist that are beyond the control of either the person applying or the department. People may withdraw their application at any time.

2. Date of Request (DOR)

Overview

To start the application process:

- A client or someone authorized to act on their behalf must contact the department or another appropriate location with a request for benefits. This request can be in the form of a phone call, office visit or a written request by the applicant or another person or agency acting on behalf of the applicant.

- When the online OHP 7210W application is submitted online, it is time-stamped and a DOR established for the applicant.

- The department may also initiate the application process and establish a DOR for the client.
• Hospitals call the OHP Application Center to establish a date of request (used to be called a “hospital hold”) when an individual is admitted. To find out if there has been a date of request for the applicant, call the OHP Application Center at 1-800-359-9517.

New applicants

The date of request for new applicants is the day medical care began, if the actual request is made no later than the next working day. If the request is received later than the next working day, the day the request is received by the department is the date of request.

To apply for medical, a person or someone authorized to act on their behalf must either contact a branch office serving the area they live in, an outreach center, including an authorized Federally Qualified Health Center (FQHC) or a Disproportionate-Share Hospital (DSH), or call the toll-free number 1-800-359-9517, with a request for benefits. A request may be in the form of a phone call, a visit to the office or in writing.

For new applicants, in order to maintain the original date of request, the person’s application form must be received in a branch office no later than 45 calendar days from the date of request. If the 45th day falls on a weekend or holiday, the application must be received the following working day. If the application is not received within 45 days, the actual date the branch office receives the application becomes the new date of request. The 45-day policy does not apply to recertifications.

For Healthy KidsConnect, the date of request will not establish the date medical benefits begin. The 12-month HKC eligibility period begins the first of the month following the date the HKC decision is made.

Once referred to OPHP, HKC subsidy clients will have 45 days to contact DHS or OPHP to enroll in a plan after eligibility has been established. HKC subsidy and HKC ESI reimbursements begin after the client enrolls in a health plan contracted through OPHP.

The date of request for a medical application, which is date stamped on the application form, may also be established by a branch, by the toll-free operator or by a worker at an outreach center. For OHP 7210W online applicants, a DOR is established when the OHP 7210W is successfully submitted by the applicant over the internet and received by the department.

DOR at redeterminations

For redeterminations (including OHP recertifications), the date of request is the date the application is received by the department, the date the client otherwise establishes a date of request or the department establishes a DOR for the client (as for example, when acting on a reported change).

Note: The requirement to submit a written application within 45 days of the original date of request affects new applicants. Ongoing clients have a written application already on file.
For Healthy KidsConnect families at or over 301 percent, redeterminations will not be made every year by DHS. OPHP will handle these redeterminations.

For HKC subsidy and HKC ESI reimbursement clients turning 19 years old, the Statewide Processing Center (Branch 5503) will redetermine eligibility for ongoing benefits.

**Randomly Selected OHP Standard Reservation List Applicants**

Persons randomly selected from the OHP Standard Reservation List must establish a DOR within 45 days from the date the OHP 7210R is mailed. If the OHP Standard Reservation List Applicant does not establish a DOR within 45 days, the client may request an ADA accommodation. If the client does not qualify for an ADA accommodation, treat as a new OHP-OPU applicant.

SEE MA E-8 FOR MORE INFORMATION ABOUT THE OHP STANDARD RESERVATION LIST PROCESS.

**Date of Request:** 461-115-0030

**When An Application Must Be Filed:** 461-115-0050

**Authorized Representatives; General:** 461-115-0090

**Offices Where Clients Apply:** 461-115-0150

**Application Processing Time Frames; Not SNAP or Pre-TANF:** 461-115-0190

**OHP-OPU; Effective Dates for the Program:** 461-135-1102

**Reservation Lists and Eligibility; OHP-OPU:** 461-135-1125

**Effective Dates; Initial Month Medical Benefits:** 461-180-0090

3. **Reviewing for Multiple Medical Programs**

Workers must review for all medical programs when evaluating for initial medical eligibility, when acting on timely reported changes and at regularly scheduled redeterminations:

When reviewing for initial medical eligibility:

- First consider all medical programs except OHP, CEM, CEC and Healthy KidsConnect.

- If not eligible, then evaluate for OHP. For non-CAWEM children under age 19, if not eligible for OHP, evaluate for CEM and CEC.

- If not eligible for any of the above, for non-CAWEM children under age 19, evaluate for Healthy KidsConnect.
4. **Referrals to OPHP**

DHS refers client information to the Office of Private Healthy Partnerships (OPHP) to support Healthy Kids.

- Healthy KidsConnect (HKC) is part of Healthy Kids. HKC cases are referred to OPHP automatically once the HKC coding is added to the CM system. Once referred, OPHP works with the HKC families to issue benefits.

- Some HKC families from 201 percent to 301 percent (KCA) qualify for a subsidy of their employer sponsored insurance (ESI). If ESI is available to a KCA family, but the child is not receiving it yet, send an e-mail to OPHP at Info, OPHP with the insurance information.

- When KCA families are receiving private major medical but qualify for a waiver of the two-month waiting period, send an e-mail to OPHP at Info, OPHP with the insurance information.

- When sending an e-mail to Info, OPHP include:
  - Case number
  - Case name
  - Name and phone number of the insurance company, or for employer sponsored insurance, the name and phone number of the employer
  - The names of child(ren) that are covered by the insurance

*THE CM SYSTEM CODING AND REFERRAL REQUIREMENTS FOR HKC FAMILIES ARE INCLUDED IN THIS CHAPTER, SECTION E.17.*

- In addition to HKC families, OPHP also support HK by providing a 100 percent subsidy payment for a child’s employer sponsored health insurance in certain circumstances.

When a non-CAWEM Medicaid or CHIP child is **not** receiving employer sponsored insurance but it is available to them:

- Add the ESP need/resource item with a Continuous end date (ESP C) to the child on the CM case.

- Send an e-mail to INFO, OPHP.

- OPHP and the family will review available health insurance options. If the family chooses to end Medicaid/CHIP coverage, OPHP will notify the worker.
5. Referrals to SPD

Clients that indicate they have disabilities should be referred to SPD, if appropriate, using your local referral process. Do so only after evaluating for all “Plus” Self-Sufficiency medical programs. SPD referrals for applicants who may only be considered for OHP-OPU should be completed immediately, even in cases where the applicant will be pended for OHP-OPU eligibility.

Check with your lead worker or manager for more information about your branch’s referral process for OSIPM. CAF Self-Sufficiency and SPD have jointly developed a Worker Guide explaining the process. The SPD WG-4 “Presumptive Medicaid Decision Procedures” is available at: http://www.dhs.state.or.us/spd/tools/program/osip/wg4.htm

Clients referred to SPD for an OSIPM eligibility decision should be sent the GSOSIPR “OSIPM Referral” notice available on Notice Writer. Clients denied for Self-Sufficiency medical prior to the referral will also need to be sent the Notice of Self Sufficiency Medical Program Eligibility Decision (DHS 462C). The DHS 462C is available on the DHS forms web page and as a two part Notice Writer notice CM462C1 and CM462C2.

6. Redetermination of Medical Assistance Eligibility

Redetermination Process Defined

Redetermination is the process used to review eligibility to approve, close or deny the continuation of benefits. This process includes a review of the new or existing application and supporting documentation. It also includes an evaluation of eligibility for all Self-Sufficiency medical programs prior to ending benefits. People must cooperate in the process or their benefits will stop.

Special CW Referral Process

When children lose eligibility for foster care, CW sends a referral to the OHP Statewide Processing Center (branch 5503). Eligibility workers add the children as MAA clients and redetermine their eligibility for ongoing medical. If not eligible for any SSP or SPD OHP Plus medical, the children are converted to CEM for the balance of their 12-month eligibility period.

SEE MA.E 16 FOR MORE INFORMATION ABOUT THE CEM PROGRAM.

Frequency of Redeterminations

Redetermination is done at assigned intervals, whenever eligibility becomes questionable or when acting on a change that affects current medical eligibility.

- Periodic redeterminations are done every 12 months for the MAA and MAF programs. To ensure that children under age 19 have a 12-month period of
eligibility, do not adjust the MAA/MAF redetermination date to match SNAP or other companion cases redetermination dates.

- Children receiving Continuous Eligibility for Medicaid (CEM) or Continuous Eligibility for CHIP (CEC) are redetermined at the end of their CEM or CEC period.

  SEE MA.E FOR MORE INFORMATION ABOUT 12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN.

- Periodic redeterminations are done at least every 12 months for BCCM.

- There is no redetermination for EXT.

- OHP redeterminations are based on the OHP certification periods. See OHP Certification Period below.

- HKC subsidy and HKC ESI redeterminations will be made after 12 full months from the eligibility approval date.

- For all SSP medical programs, a redetermination is completed whenever a change has been reported timely that affects current medical eligibility.

**Note:** The CM system will close MAA and MAF cases based on the MAA or MAF need/resource item on CMUP and will send the “CR” close notice. The CM system will close MAA/TANF cases if the only child was an unborn or the only eligible child is turning 19. The CM system also automatically ends MAA for dependent children turning 19, even if there are other dependent children on the case. CM will not close if there is a protected AEN or pregnant woman.

**Note:** The CM system will close the HKC subsidy and HKC ESI eligibility based on the KCR need/resource end date.

**There is usually no need for a new application at redetermination/recertification**

Clients who are receiving a DHS program (even if the program is not a medical program) do not need to complete a new OHP 7210 or DHS 415F application when requesting medical.

It does not matter when the application was originally signed, as long as the client is currently receiving DHS program benefits at the time they make the request for medical.

Review the existing OHP 7210 or DHS 415F and all the information on the original application. Determine what eligibility items need to be verified and send a pend notice.

If there is no current application available in the imaging system or in the file, require a completed application.
Amending the original application

Sometimes an application may need to be amended. If someone has moved into the household and is in the medical filing group, the worker may pend to have the existing application updated by the client. (When a client updates an existing application, the client is amending the application).

- To request the application be amended to include the new filing group member’s name, SSN, DOB and other information in the “Tell us about the people in your household” section of the DHS 415F or question 2 of the OHP 7210. Send copies of the pages of the DHS 415F or OHP 7210 that need to be amended to the client with a pend notice.

Instead of sending copies of part of the original application, caseworkers may use the DHS 415X “Additional Space for Other People Living with You” or OHP 7226 “Additional People” form.

- If the new person in the medical filing group is required to sign the application, request the application be amended to include the new filing group member’s signature. Send copies of pages 8 through 14 of the original DHS 415F or pages 3 and 4 of the original OHP 7210 to the client with a pend notice.

Example: Mary and her three children are receiving SNAP benefits. Mary loses her health insurance and requests medical. The worker may use the DHS 415F used for the SNAP application to determine eligibility for medical.

Pending for a new application

Instead of sending copies of part of the original application to be amended, the family may be sent a new application.

- When requesting a new application, completion of the application becomes an eligibility requirement. The family must be pended for completion of the new application.

Note: If the client submits a new reapplication packet, new signatures are also required. For example, in a two-parent household, require both parents to sign the reapplication. Do not use the signatures on the old application. If one of the parents is unavailable to sign the application, an exception may be approved on a case-by-case basis. E-mail the request to SSP-Policy, Medical.

Example: Joan and her two children are receiving SNAP and ERDC. Joan reports that her husband John has returned to the household. Joan requests medical for herself, her husband Johan and their two children. The worker may use the DHS 415F used for the SNAP eligibility to determine eligibility for medical.
However, because John is new to the household and also must sign the application, the worker needs information about John and also John’s signature on the application. Instead of amending the existing application, the worker may opt to require a new application and sends a pend notice requesting the new application.

**BED Coding for Periodic Redeterminations or When Acting on a Reported Change**

For periodic redeterminations or when acting on a reported change that affects medical eligibility in the BCCM, CEC, CEM, EXT, HKC, MAA, MAF, OHP, OSIPM and SAC programs, give the filing group 45 days from the date of request to re-establish their eligibility.

**Note:** Although client’s report of a change must be timely in order to be eligible for the 45-days extension, a state agency’s report of a change need not be timely.

If there is not enough time to process the periodic redetermination or act on the reported change, add the BED need/resource item. The BED end date should provide enough time to pend and/or send a 10-day notice to close or reduce benefits.

If not removed, the CM case will use the BED code to send the 77B 10-day close notice on the 15th of the month. If the 45th day is after the 15th, the BED end date should be the next month.

The Bypass End Date (BED) coding works correctly only when there is a medical end date to bypass. If necessary, change the medical end date to the current month. For example, if the MAA need/resource end date is 12/10 and the client reports a change requiring MAA redetermination in 07/10, send the pend notice, change the MAA end date to 07/10 and add the BED code.

*See Medical Assistance WG-10 for more information about BED coding.*

**If the client is still eligible, but for a reduced benefit package:** If the client has turned in enough information to make an eligibility decision and they are no longer eligible for the same level of benefits, for all but HKC subsidy referrals (KCA coding) send a notice stating the specific reason why their benefits must be reduced.

*Example:* CW notifies you the only eligible child has been removed from the MAA household. Before ending the parent’s MAA medical, consider OHP-OPU for the parent. Pend as needed to verify OHP-OPU eligibility. If eligible for OHP-OPU, send a timely continuing notice of reduction, Notice of Decision or Action.

*Example:* If the client has turned in enough information to make an eligibility decision determine if their HKC income is from 201 percent to 301 percent or is 301 percent or above. Add the BED coding and KCA coding to each child on the CM case. The CM system will
automatically refer the children to OPHP. The referral notice includes information about the reduction.

**Example:** If the client has turned in enough information and the family has income 301 percent and above, the children do not qualify for any DHS medical program assistance. Use the BED coding only if necessary to send the 10-day close notice and the DHS 462A notice. On a Compute action, end the current benefits and add the KC3 coding to each child on the CM case. The CM system will automatically refer the children to OPHP.

**Example:** CW notifies you the only eligible child has been removed from the MAA household. Before ending the parent’s MAA medical, consider OHP-OPU for the parent. Pend as needed to verify OHP-OPU eligibility. If eligible for OHP-OPU, send a timely continuing notice of reduction, Notice of Decision or Action Taken (DHS 456), and convert the parent’s MAA medical to OHP-OPU medical the first of the month after the timely continuing notice period.

**If the client is not eligible for SSP medical anymore, but could be eligible for SPD medical:** When a decision has been made that the client is no longer eligible for SSP medical, determine if the client could be eligible for SPD medical. If they could be eligible for SPD medical, complete a referral and if already receiving SSP medical, keep the SSP medical open until SPD has made a decision. Use the BED coding to keep the case open. Do not send a close notice or DHS 462A until SPD has made a decision.

☞ SEE MEDICAL ASSISTANCE B. 4 FOR MORE INFORMATION ABOUT SPD REFERRALS.

**If the client’s case has to be pended:** Once the BED coding has been added to a pended case, if the client does not return the pended, the CM system will automatically send a timely continuing (10-day) close notice; the worker will not need to send a separate close notice. No DHS 462A is required.

**Note:** If circumstances or information needed to determine eligibility is expected to be received after the 45-day deadline and the client has no control over the circumstances or information, the 45-day application process may be extended.

☞ SEE MEDICAL ASSISTANCE WG-10 FOR MORE INFORMATION ABOUT BED CODING.
7. **OHP and HKC Certification Period**

The intent of the OHP and HKC certification period is to give most people a continuous period of medical assistance and to review their eligibility on a periodic basis.

The certification period is the number of months between the person’s initial eligibility and when a recertification of eligibility is due, or between one recertification and the next. The certification period is determined as follows:

- For OHP, the initial certification period consists of the month containing the effective date for starting medical benefits and the following six months for OPU. For OPC, OP6, and CHP clients, the initial certification consists of the month containing the effective date for starting medical benefits and the following 12 months.

- For HKC children who are eligible for a subsidy (201 percent to 301 percent income), the initial certification period consists of the month containing the OPHP referral date and the following twelve months. Use the KCR need/resource code to indicate the twelfth month. Children referred with family income at 301 percent and above are not DHS clients and do not have a certification end date.

  SEE MA E.17 FOR HKC CODING REQUIREMENTS.

- For OHP and HKC recipients, the next certification period is the following six-month period for OPU. For OPC, OP6, CHP and HKC subsidy (income from 201 percent to 301 percent) recipients, the new certification period is the following 12-month period.

- When a person receiving OHP starts working under a JOBS Plus agreement, extend the certification period to one month beyond the end of the agreement. If the agreement ends early, shorten the period to the original date or the month following the month in which the agreement ends, whichever is later.

**How to recertify BEDded Cases**

If eligible for OHP, any month the client receives benefits because the case had been BEDded counts toward the next OPC, OP6, CHP or OPU certification period.

When recertifying a BEDded case, remove the BED code. Enter a Compute action for the first of the next month. Change the medical case descriptor if necessary and update the OPC, OP6, CHP or OPU need/resource end date. Change the medical start date on CMUP for the recertified client to the first of the next month.

For example, an OPC child’s certification is due to end April 30. On April 14, the family reapplies for OHP benefits and the case is BEDded for 06/09. On May 5, the child is determined to be eligible for CHP. Remove the BED code. Compute for June 1, 2009, and enter a CHP need/resource end date of 04/10. Change the child’s medical start date to June 1.
Note: At the time this is being written for the April 2010 FSM release, the HKC redetermination policy has not been finalized. At this time, it appears ongoing HKC subsidy clients (income 201 percent to 301 percent with the KCE case descriptor) will not be BEDded at redetermination. Additional information will be distributed via transmittal when more information about the HKC redetermination process is available. If you have any questions, please contact an SSP Medical Policy analyst or e-mail the generic SSP medical policy e-mail address, SSP-Policy, Medical.

Adding/removing persons from an OHP case

Note: At the time this is being written for the April 2010 FSM release, the policy for adding/removing persons from HKC cases eligible for an HKC subsidy (201 percent to 301 percent income with KCA or KCE case descriptor) has not been finalized. Additional information will be distributed via transmittal when more information about the policy is available. If you have any questions, please contact an SSP Medical Policy analyst or e-mail the generic SSP medical policy e-mail address, SSP-Policy, Medical.

When a new person (other than an assumed eligible newborn) wants to be added to an ongoing case, the entire group must establish a new certification period. If the new certification would make the current benefit group ineligible, the original benefit group remains eligible for the remainder of their certification period.

Example: Mary and her two daughters are receiving OHP. Her son John had been living with his father, but has returned to live with Mary and his sisters. John is not receiving any health care coverage, so Mary applies for medical for John on October 15, 20XX. Determine eligibility for Mary, her two daughters and John. If eligible, recertify Mary (giving her a new six-month OPU certification) and her two daughters (giving them a new 12-month certification) and certify John from October 15, 20XX and the following 12 months.

Note: If John is not eligible for medical, send a denial notice and DHS 462A notice. Keep Mary and her two daughters on their original certification.

When a person leaves an OHP benefit group, that person is still eligible through the end of the certification period as long as he or she meets the nonfinancial and specific program requirements. Those remaining in the original benefit group also are still eligible through the end of the certification period if they continue to meet the nonfinancial and specific program requirements. A different case will need to be opened for the person who left the group. If the person is paying premiums as required under the OHP-OPU program, the premium status from the original case will not be updated on the new case.
**Information about OHP certifications**

A pregnant woman eligible for OHP is not assigned an eligibility period. She is assumed eligible through the last day of the month in which the 60th day following her pregnancy falls. When her assumed eligibility period ends, she needs to reapply to continue to receive benefits even if the certification period for others in the group extends beyond her assumed eligibility period. The computer system uses the DUE need/resource date to determine the period of eligibility. If the pregnancy ends in a month other than the date coded, it is important to change the DUE need/resource date so the person receives the correct period of coverage.

**Combining OHP households**

When a recipient moves into the household of another recipient, they must be combined into one case if all of the recipients are required to be in the same filing group. When cases are combined, extend the certification period to the latest date for any of the persons in the group.

**Affect of reported changes on the certification period**

Once a person is determined eligible for OHP, any changes in the filing group’s household composition, income or resources, does not affect their eligibility during their current certification period. However, other changes (such as residency, citizenship, and student status) can affect eligibility.

SEE SECTION E (MA E) OF THIS CHAPTER FOR MORE INFORMATION.

Certification Period; OHP: 461-115-0530
Assumed Eligibility for Medical Programs: 461-135-0010

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**8. Verification of Eligibility**

The intent of verification is to ensure that the verbal or written information given by a person is the true information.

People must provide verification of their eligibility when requested. Branch staff may determine what is acceptable verification for specific eligibility requirements and situations. An application may be denied or ongoing benefits ended when acceptable verification is not provided; however, federal policy is clear that ongoing medical clients are “eligible until no longer eligible.” Be sure to list the reason(s) why eligibility needs to be verified on the pend notice. Do not forget to narrate the eligibility factor that needs verification.

FOR EXAMPLES OF DOCUMENTS USED FOR VERIFICATION, SEE MULTIPLE PROGRAM WORKER GUIDES #2 ON VERIFYING CLIENT INFORMATION.
For all medical assistance programs, verify the following whenever it is reported, changed or as needed for eligibility determination:

- Pregnancy. This must be verified by a medical practitioner, a health department or clinic, or a crisis pregnancy center or other like facilities. Due date verification is not required except when the only child is an unborn child for MAA and MAF or when a CAWEM client is part of the Pre-natal Expansion Pilot Program.

  For more information about the Pre-natal Expansion Pilot, see NC C.3.

- Birth of a child.

- Amount of the premium for cost-effective employer-sponsored health insurance.

- Income. If income cannot be verified, accept the client statement and narrate the income calculation. For example, if the client has moved to Oregon from another state, has no pay verification and the employer refuses to provide verification to the client or the department, accept the client’s statement of gross earnings and narrate.

  Verify income received at the time the application is initially worked. For example, if the DOR is 1/1/10 and the application is first worked on 1/20/10, verify any income received 1/20/10 or earlier as needed to make the eligibility decision.

  For HKC families with income 301 percent or above, do not pend for income verification in order to deny the case.

  See MA-E.17 for information about HKC eligibility and system coding requirements.

Note: Verification of self-employment costs is not required for OHP and MAF unless questionable.

Citizenship. Acceptable evidence of citizenship must be provided, but if the client is unable to provide documentation at initial application (and is otherwise eligible for medical), open, code with the CIP N/R, and pend for documentation. If the client does not provide documentation, the CM system will send a close notice and end benefits. The policy applies to all medical program clients, including pregnant women who were opened and then required to provide documentation, but did not do so.

Once a client’s medical has been closed for failure to provide citizenship documentation, unless they have good cause, they must provide documentation before they receive benefits again.

See Medical Assistance D.5 for more information about when citizenship documentation is required.
• Noncitizen status. Handle as we do citizenship documentation. Acceptable evidence of noncitizen status must be provided, but if the client is unable to provide documentation at initial application and declares a noncitizen status that meets the requirements, open medical and pend for noncitizen documentation.

Once a client’s medical has been closed for failure to provide citizenship documentation, unless they have good cause, they must provide documentation before they receive benefits again.

Reverify noncitizen documentation at each eligibility determination.

Note: The CM system will have coding to support non-citizen documentation requirements soon. Until the new coding is added, eligibility workers must send the close notice for failure to provide noncitizen documentation and manually end medical.

For all other eligibility requirements – i.e., residence, age, resources – accept the person’s statement unless it is questionable or inconsistent.

Any eligibility requirement may require verification when information is questionable or inconsistent with any of the following:

• Other reported information.
• Other information provided on the application.
• Other information received by the branch office.
• Information reported on previous applications.

EXT. Verify the following eligibility requirements for EXT:

• For initial EXT eligibility based on an increase in child support verify that at least one person in the EXT filing group received MAA or MAF for three of the six months preceding the first of the EXT eligibility period.

• Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

MAA/MAF. Verify the following eligibility requirements for MAA and MAF:

• Social Security Number or an application for a number.
• Citizenship. Acceptable evidence of citizenship must be provided for some MAA/MAF recipients.

SEE MEDICAL ASSISTANCE D.5 FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.
- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

  \[\text{See Section A.1 of the Noncitizens Chapter for more information on verification of alien status.}\]

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.

- Income.

- Incapacity for deprivation based on incapacity. Other deprivation requirements as needed.

  \[\text{See TANF E in the Temporary Assistance for Needy Families Related Programs Chapter for more information on deprivation.}\]

**SAC.** Verify the following eligibility requirements for SAC:

- Social Security Number or an application for a number.

- Citizenship. Acceptable evidence of citizenship must be provided for some SAC recipients.

  \[\text{See Medical Assistance D.5 for more information about when citizenship documentation is required}\]

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

  \[\text{See Section A.1 of the Noncitizens Chapter for more information on verification of alien status.}\]

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.

- Income and resources for children in substitute care.

- Eligibility for adoption assistance for adopted children. The family of a child receiving adoption assistance from another state should have a letter or a copy of the Adoption Assistance Agreement from that state that will confirm the child’s eligibility for adoption assistance.

**OHP.** When people apply for OHP, verify the following eligibility requirements for the initial application:

- Social Security Number or an application for a number.
• Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

**Note:** If the applicant declares an immigration status that would meet the alien status requirements, does not have verification of their status but is otherwise eligible for full (not CAWEM) medical, open medical and pend for verification of immigration status using the CMNCSPD (Pend Medical; Proof of INS Status) Notice Writer notice. Close medical if the client does not show a good faith effort to provide the requested documentation. CM system coding will be added to support the process. Until it is available, please track the pend period and, if necessary, send a close notice and DHS 462A and end benefits.

• American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.

• Income from each month used to determine a person’s eligibility.

• Mailing address.

Verify the following when an OHP case is being recertified:

• Citizenship. Acceptable evidence of citizenship must be provided for most OHP recipients as soon as possible after opening benefits. If the client is unable to provide documentation and says they need more time, extend the pend period.

• Alien status status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

• Unearned income if it has changed since the previous certification.

• Earned income from each month used to determine eligibility.

• Mailing address. A mailing address is required to complete an application. However, there is no length of residency requirement for Medicaid. A person can move within the state, or from out-of-state, and the length of residency cannot be considered in determining eligibility.

In verifying a mailing address, workers should be reasonable and not create any barrier to accessing benefits. Medical cards may be sent to any place the person chooses, such as a post office, general delivery or public shelter, or the person may...
pick up the card at his/her local branch office. This choice is particularly applicable for newly arrived or homeless applicants.

**HKC.** Verify the following eligibility requirements for HKC:

- Social Security Number or an application for a number.

- Citizenship

  - SEE MEDICAL ASSISTANCE D.5 FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Alien status

  - SEE SECTION A.1 OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.

- Income from each month used to determine a person’s eligibility.

When An Application Must Be Filed: 461-115-0050
Verification; General: 461-115-0610
Required Verification; BCCM, HKC, MAA, MAF, OHP, SAC: 461-115-0705
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Example: John submits a DHS 415F application and says he has an emergent need for medical. Following his branch’s emergent need process, his OHP-OPU eligibility is pended. The worker updates the pend reasons on the Reservation List Web site.

Example: Later John turns in the pended items. The worker opens his CM system case, adding an LST need/resource item with John’s reservation number from the Reservation List Web site. The worker also updates John’s reservation on the Reservation List Web site to show John has been approved for OHP-OPU.

Example: Tina is a single adult who is not pregnant, has no children, and has no disabilities. She is currently not receiving benefits under any DHS medical program and was not randomly selected from the OHP Standard Reservation List. She may not be considered for OHP-OPU.

Example: Marvin is a single adult who was selected from the OHP Standard Reservation List on October 15. He was mailed a letter letting him know he had been selected and that he needed to establish a DOR within 45 days of the date the OHP 7210R was mailed. The OHP 7210R was mailed October 26. On January 15, Marvin called his local SSP office and asked for medical. He may not be considered for OHP-OPU.

Example: Curt is a single adult who is receiving OHP-OPU. His certification ends on August 31. Curt turns his recertification in timely in August. Since Curt has reapplied timely, he can be considered for OHP-OPU.

Example: Larry is receiving OHP-OPU and his children are receiving OHP-OPC. His certification ends on August 31. He turns in his recertification late on September 1. His family is not eligible for MAA or MAF. Although his children can be considered for OHP, Larry cannot be considered for OHP-OPU.

SEE MEDICAL ASSISTANCE CHAPTER B.3 FOR MORE INFORMATION REGARDING THE REQUIREMENT TO REVIEW FOR ALL MEDICAL PROGRAMS.

In addition to other OHP eligibility requirements, an OHP-OPU client:

- Must not be covered by private major medical health insurance. Private major medical health insurance means health insurance coverage that provides medical care for physician and hospital services, including major illnesses, with a limit of not less than $10,000 for each covered individual.
Must not have been covered by private major medical health insurance during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if:

- The person has a condition that without treatment would be life-threatening, or would cause permanent loss of function or disability;

- The person’s private health insurance premium was reimbursed under the provisions of OAR 461-135-0990;

- The person’s private health insurance premium was subsidized through FHIAP; or

- A member of the person’s filing group was a victim of domestic violence.

**Note:** OPU applicants receiving services through Indian Health Services or who have TPL that the tribe pays for are still eligible for OPU.

Some applicants who receive medical benefits through the Veteran’s Administration (VA) are not eligible for OHP. VA benefits are considered major medical. There are VA hospitals in Portland and Roseburg. There is also a VA hospital in Walla Walla, used by many Oregon veterans. There are clinics in Eugene, Bandon, Salem, Klamath Falls, Brookings, Bend, White City, and Warrenton. If an applicant has access (or has had access in the prior six months) to care through a local VA facility (including the Walla Walla hospital), they are usually not eligible for OHP benefits. If the client says the hospital or clinic is not accessible or says that the Veterans benefits do not cover their medical needs, then the client may be OPU eligible. If you are not sure, contact a medical policy analyst.

Must meet the following eligibility requirements:

- OHP resource limit.

- OHP budgeting requirements (using only the two-month income average to determine eligibility unless DV).

- Payment of premiums unless exempt.

- Selection of a medical, dental and mental health Managed Health Care Plan (MHCP) or Primary Care Case Manager (PCCM) if available, unless exempted by OAR 410-141-0060.

**Higher Education Students.** When an OHP-OPU person is attending a higher education institution full time, they are not eligible unless they:
9. **Second OHP Category: Oregon Health Plan for Children (OHP-OPC)**

These are persons under the age of 19 in a filing group with income under 100 percent of the income limit. If income is at or above 100 percent, the person may qualify at either the OHP-OP6 (133 percent) or OHP-CHP (201 percent) level. However, assumed eligible newborn children under the age of one who are at or above the OHP-OP6 (133 percent) are to be coded OHP-OPP and not OHP-CHP.

10. **Third OHP Category: Oregon Health Plan for Children Under Age 6 (OHP-OP6)**

These are persons under the age of six in a filing group with income over the OHP-OPC (100 percent) income standard, but below the OHP-OP6 (133 percent) income limit.

Specific requirements; OHP: 461-135-1100

11. **Fourth OHP Category: Oregon Health Plan for Pregnant Females Under 185 Percent and Their Newborn Children Under One Year of Age (OHP-OPP)**

This category includes pregnant females in a filing group with income below the 185 percent income limit and their assumed eligible newborn children at or above the OHP-OP6 (133 percent) income limit.

Specific requirements; OHP: 461-135-1100

12. **Fifth OHP Category: Oregon Health Plan for Children (OHP-CHP)**

These are persons who may qualify for medical assistance under the Children’s Health Insurance Program (CHIP). The CHIP program is not a Medicaid Title XIX program, but is provided through another federal program, title XXI, which was a provision of the federal Balanced Budget Act of 1997. They are under the age of 19 who are not eligible under the OHP-OPC, OHP-OP6, or OHP-OPP categories. The financial group’s income must be over the OHP-OPC (100 percent) income limit for children ages 6 through 18 or over the OHP-OP6 (133 percent) income limit for children under age 6 or over the OHP-OPP (185 percent) income limit but below the OHP-CHP (201 percent) income limit.

OHP-CHP persons must meet all the following requirements:

- Must provide or apply for an SSN.
- Verification of Citizenship or alien status requirements.
- Must not be pregnant with income less than 185 percent (code OHP-OPP if pregnant and less than 185 percent of the FPL).
Pregnant children (under age 19) with income from 185 percent to 201 percent of the FPL may receive CHIP. Do not forget to add the new CDU (CHIP DUE) need/resource item, unborn child and father of the unborn to the CHIP child’s CM case.

**Note:** Eligibility for pregnant CHIP women is limited. If the pregnant CHIP woman loses CHIP eligibility at redetermination (turning age 19 or at the end of the CHIP 12 month certification), convert to Continuous Eligibility for CHIP pregnant children.

![SEE SECTION 16 BELOW FOR MORE INFORMATION ABOUT CONTINUED ELIGIBILITY FOR CHIP PREGNANT CHILDREN.](image)

**Note:** Children born to pregnant CHIP women are assumed eligible for Medicaid for one year. Code the child as an OHP-OPP AEN on the CM case.

- Selection of a medical, dental and mental health Managed Health Care Plan (MCHP) or Primary Care Case Manager (PCCM) if available, unless they are exempt per DMAP OAR 410-141-0060.

- With a few exceptions listed below, the child must not be covered by private major medical health insurance. Private major medical health insurance means health insurance coverage that provides medical care for physician and hospital services, including major illnesses, with a limit of not less than $10,000 for each covered individual.

- Do not delay CHIP eligibility solely because the child is covered by Kaiser Child Health Program or Kaiser Transitions Program medical. Kaiser will end their medical after the CHIP medical eligibility is opened. Be sure to send HIG a DHS 415H with the Kaiser coverage information. Include the information that the coverage does not affect CHIP eligibility.

**Note:** Effective March 26, 2010, the OHP Statewide Processing Center (Branch 5503) will process SSP applications for children in Kaiser Permanente’s Child Health Program or Transitions Program. Fax the application to 5503 at 503-373-7493. A cover letter was developed to support the process. Be sure to include the “Attention” cover letter when faxing the application. The cover letter will be posted to the SSP medical Web site the week of March 29.

- Do not delay CHIP eligibility solely because the child is receiving services through Indian Health Services or has major medical paid for by the tribe. Be sure to send HIG a DHS 415H with the Indian Health Service coverage information. Include the information that the coverage does not affect CHIP eligibility.

- Unless covered by Kaiser Child Health Program, Kaiser Transitions Program, Indian Health Services or tribal paid health coverage, the child must not have been covered by any private major medical health insurance in the past two months. The two-month waiting period is waived if any of the following are true:
To make a PHI referral complete Sections 1 through 4 on the revised DHS 3073 and fax it to HIG at 503 373-0358. You must include a copy of the DHS 415H or SDS 415H.

Other documentation may be required such as the *Authorization for Use and Disclosure of Information* (DHS 2099), medical records, doctor letters or chart notes. If any of these are already available they should be faxed along with the DHS 3073. It is not necessary to request these before making the referral but if they are already available, sending them with the referral can shorten processing time.

Caseworkers and clients are notified by mail after the PHI eligibility determination has been made.

☞ SEE DMAP WORKER GUIDE # 7 FOR MORE INFORMATION.

### 15. Breast and Cervical Cancer Medical (BCCM)

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) amended Title XIX (Medicaid) of the Social Security Act to give the option of providing Medicaid eligibility to uninsured women who are screened by the Centers for Disease Control and Prevention’s National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including precancerous conditions.

No income or resource limits exist for the BCCM program.

To be eligible for the BCCM program, a woman must:

- Have been screened by the Oregon Breast and Cervical Cancer Program, which is coordinated by the DHS Health Services and paid for by NBCCEDP, and is in need of treatment for breast or cervical cancer, or precancerous conditions.

- Be **under the age of 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.)

- Be **uninsured**. She must not have creditable coverage for the needed treatment of breast or cervical cancer, or precancerous conditions, by health insurance.

- Creditable coverage includes:
  - Individual or group health insurance.
  - Medicare.
  - Medicaid.
  - Armed forces insurance.
- Family Health Insurance Assistance Program (FHIAP).
- Oregon Medical Insurance Pool (OMIP).

- Not be eligible under any of the mandatory Medicaid programs (MAA, MAF, Medicaid for pregnant women and children or OSIPM).

The Oregon Breast and Cervical Cancer Program of DHS Health Services provides grants to local county health departments and tribes throughout the state to administer screening and diagnostic services. Local program staff provide case management services.

Because a woman must be screened by the Oregon Breast and Cervical Cancer Program and found to need treatment to be eligible for BCCM, the application process is initiated by an Oregon Breast and Cervical Cancer Program Coordinator who assists the woman in completing a BCCM application form upon receiving a diagnosis of cancer or precancerous condition. The coordinator submits the BCCM application form to the Statewide Processing Center to establish eligibility. If it appears the woman could be eligible for a mandatory Medicaid program, the coordinator will assist the woman in requesting an Application for the Oregon Health Plan (OHP 7210) from the application center. The OHP 7210 will be marked “BCP” on the label. If a woman submits the OHP 7210 to a branch office, it is to be forwarded to the Statewide Processing Center.

A woman found eligible for the BCCM program will have her case coded as program P2 with a BCP case descriptor. If the woman is later determined to be eligible under any of the mandatory Medicaid programs, her case will be coded with that program coding and with a BCS case descriptor.

A woman who loses eligibility for another medical program, but has her case coded with the BCS case descriptor, is still eligible for the BCCM program as long as she still needs treatment and continues to meet all other eligibility requirements for the program.

A woman is no longer eligible for the BCCM program when:

- Her course of treatment has been completed.
- She reaches age 65.
- She becomes covered for treatment of breast or cervical cancer by credible health insurance.
- She is no longer a resident of Oregon.

For information regarding the screening and diagnostic services of the Oregon Breast and Cervical Cancer Program, contact the local county health department or call DHS Health Services at (503) 731-4273. Information about the program can also be found on the program’s Web page at http://egov.oregon.gov/DHS/ph/bcc/index.shtml.
brings in proof of pregnancy; she is not due until March 2010. She
is coded CHP with a redetermination date of 12/2009 and also
CDU with a due date of 3/2010. At her December redetermination,
it is determined her household income is now above 201 percent
FPL. The worker codes her CEC of March 2010, and CDU for
March 2010.

Example 5: Bethany, an 18-year-old who is pregnant with a due date of March
2010, is receiving CHIP and scheduled for redetermination in June
2010. Bethany receives major medical health insurance through an
absent parent in December 2009. She is no longer eligible for
CHIP, and is not eligible for CEC due to the major medical health
insurance. The worker closes her benefits December 2009 after
sending a timely closure benefit notice DHS 462A.

Special 5503 OP6 procedure:

The OHP Statewide Processing Center (branch 5503) currently receives a monthly report
of children turning age 6. Staff from 5503 will review the report and redetermine
eligibility for each OP6’s filing group. The procedure will remain, but be expanded to
include Continuous Eligibility for Medicaid.

Example: Chad is a U.S. citizen. He is certified to receive OP6 through
June 30 of next year. Chad turns age 6 in February.

In January, the OHP Statewide Processing Center (5503) receives a
report of OP6 children turning age 6. 5503 staff review Chad’s
eligibility to determine if he qualifies for any other DHS medical
program. If not eligible for any other DHS medical program, 5503
will convert Chad to Continuous Eligibility for Medicaid (CEM) by
adding the CEM case descriptor and need/resource item. The CEM
end date will be 06/XX (the original OP6 certification end date)

Special 5503 MAA/MAF/OPP procedure:

The OHP Statewide Processing Center (branch 5503) will work a monthly report of
pregnant children under age 19 whose MAA/MAF eligibility is ending because there are
no dependent children on the case. The report will also list OPP children whose medical
is ending.

Example: Felicia is age 16 and receiving OPP. The DUE date on her CM
case is 08/09. In 07/09, 5503 will redetermine eligibility for
Felicia’s medical filing group.
17. **Specific Requirements; Healthy KidsConnect (HKC)**

**Overview**

HKC provides health insurance to families through the Office of Private Health Partnerships (OPHP). OPHP provides health insurance through HKC insurance carriers or by helping the family pay for employer sponsored insurance (ESI).

- Families with income from 201 percent of the Federal Poverty Level (FPL) up to 301 percent FPL qualify for a subsidy payment from OPHP to help them pay for the cost of the insurance. The subsidy is used to help pay the insurance premium necessary to enroll the child with an HKC insurance carrier or to help pay the ESI premium.

- Families with income from 301 percent FPL and above may choose to enroll their children with an HKC insurance carrier, but must pay for the entire premium amount.

Even though families with income from 301 percent FPL and above do not qualify for any DHS medical program, DHS is responsible for determining the family can be referred to OPHP.

HKC families are automatically referred to OPHP when the HKC (KCA/KC3 coding is entered on the family’s CM system case.

After being determined eligible for HKC and the HKC coding is entered on the family’s CM system case, an automated referral is made to OPHP. OPHP works with the family to enroll the child in one of the following categories:

(A) Healthy KidsConnect Employer Sponsored Insurance (ESI) subsidy for families with income 201 percent to 301 percent FPL;

(B) Healthy KidsConnect subsidy for families with income 201 percent to 301 percent FPL; or

(C) Healthy KidsConnect full pay for families with income 301 percent and above.

**HKC Eligibility**

To be eligible for HKC, a person must be under 19 years of age and must meet the alien status requirement. There is no CAWEM coverage under HKC.

Income treatment and availability of income requirements used for determining HKC eligibility are the same as used for CHIP.

Budgeting for HKC eligibility follows the same methodologies as those used for CHIP in 461-150-0055.

- Determine eligibility using the same two-month budgeting as CHIP.
If not eligible using the two-month average, use budget month income only.

If not eligible using the budget month only income, float the budget month.

**Note:** *Float the budget month if the family could qualify for OHP Plus or a higher subsidy level using the new budget month.*

The countable income standard for HKC is at or above 201 percent of the federal poverty limit. Families eligible for HKC with income 201 percent to 301 percent (KCS) are DHS medical program clients. They qualify for a subsidy paid for with title XXI funds. (Title XXI is also used to fund the CHIP program.)

Families eligible for HKC with income 301 percent and above (KC3 coding) are not DHS clients, but are referred to OPHP anyway. Some families with income 301 percent and above choose to work with OPHP. They choose to enroll with an HKC insurance carrier and pay the full insurance premium.

In order to be eligible for HKC, the child must be a U.S. citizen or meet qualified alien status.

- If a child does not have citizenship documentation but is otherwise eligible for HKC at 201 percent to 301 percent of the FPL, add the KCA coding to the CM case. Also add the CIP coding and send a CMCITPD or other pend notice to the family. Transfer the case to 5503 and mail/shuttle/UPS the application to 5503 using the HKC cover sheet.

- Once the citizenship documentation has been provided. Update the child’s Person Alias/Update citizenship fields, remove (or have 5503 remove) the CIP/CIE coding and narrate.

- If it has been determined the family’s income is 301 percent FPL and above, add the KC3 coding to the CM case but do not add the CIP coding or pend the family for citizenship documentation for the child. (I.e., do not pend when you are going to deny the medical application anyway).

The eligibility period for HKC is a 12-month period. Once the child is approved as eligible for HKC, the CM system refers the case to OPHP for a subsidized enrollment with an HKC insurance carrier or for an ESI subsidy payment.

To be eligible for HKC, the child must not currently be covered by private major medical health insurance or by any private major medical health insurance during the preceding two months.

**Note:** *The Kaiser Child Health and Kaiser Transitions insurance programs are not considered private major medical. Neither program affects HKC (or CHIP) eligibility.*

After the private major medical has ended, there is a two-month waiting period before the child can be enrolled by OPHP into HKC. However, if the child qualifies for a waiver of
the two-month waiting period, OPHP will ensure the private major medical has ended. Do not delay referring families to OPHP if they are otherwise eligible for HKC and qualify for a waiver of the two-month waiting period.

The two-month waiting period after the private major medical has ended is waived if –

a) The person has a condition that without treatment would be life-threatening or cause permanent loss of function or disability;

b) The loss of health insurance was due to a change in employment (includes children whose COBRA coverage has ended or whose parents choose to end COBRA coverage);

c) The person’s private health insurance premium was reimbursed by a HIP payment;

d) The person’s private health insurance premium was subsidized by FHIAP or by the Office of Private Health Partnerships (OPHP);

e) A member of the person’s filing group was a victim of domestic violence.

If an HKC child is receiving private major medical and qualifies for a waiver of the two-month waiting period:

• Code the KCA or KC3 HKC referral on the CM system.

• Send an e-mail to OPHP at “Info, OPHP” in GroupWise with the case number, case name, name of the insurance company, phone number of the insurance company or employer offering the insurance, names of child(ren) covered by the insurance. A DHS 415H is not required for HKC. The e-mail replaces the DHS 415H.

• OPHP will work with the family and the insurance carriers so that the private health insurance will be closed before the HKC benefits are issued.

See B.4 in this chapter for more information about the e-mail referral to OPHP.

Example:  John and Mary are applying for medical for their daughter Maria. Maria has a health condition that without treatment could be disabling. John and Mary have been paying for private TPL for Maria but can no longer afford the premiums. The family’s income is 252 percent of the federal poverty level (FPL) and Maria could qualify for HKC after her insurance ends.

Since Maria has a health condition that qualifies her for a waiver of the two-month uninsurance requirement, add the KCA coding to Maria on the family’s CM case. Send an e-mail to Info, OPHP letting OPHP know that Maria qualifies for a waiver of the two-month wait. List the
case number, case name, Maria’s name and the name of the insurance company (and the insurance company’s phone number, if known). A DHS 415H is not required.

Example: Sara is applying for medical for her daughter Heather. Sara lost her job, and has been paying for Heather’s insurance through COBRA. The family’s income is 205 percent FPL and Sara cannot afford to keep paying the COBRA health insurance premium.

COBRA coverage is due to a change in employment and qualifies Heather for a waiver of the two-month waiting period. Refer to OPHP by adding the KCA coding to the CM case. Send an e-mail to OPHP letting them know that Heather qualifies for a waiver of the two-month wait. Include the case number, case name and list Heather as the person qualifying for the two-month waiver. Include the name of the health insurance company and phone number (if known). A DHS 415H is not required.

Example: Jennifer is applying for medical for her son Franklin and daughter Louise. Louise is included on her absent father’s insurance, but Franklin has a different father and does not receive any insurance. Jennifer just separated from Louise’s father because of domestic violence. Jennifer explains that Louise’s father has been very upset about having to pay for Louise’s insurance and continues to threaten Jennifer.

Jennifer no longer wants to use the insurance for Louise and wants to receive medical benefits for both Franklin and Louise. The family’s income is at 220 percent FPL.

The two-month wait can be waived because of the domestic violence. Send an e-mail to OPHP letting them know Louise qualifies for a waiver of the two-month wait. Include the case number, case name and Louise’s name. Include the name of the health insurance company and phone number (if known). A DHS 415H is not required.

A child found eligible for HKC becomes ineligible if any of the following occur:

a) Upon reaching age 19: Children aging off of HKC at age 19 are not treated as new applicants for OHP Standard. They do not need to be randomly selected from the reservation list to qualify for OHP Standards as long as they establish a date of request before their HKC ends. If eligible, they may transition into OHP Standard effective the first of the month after the 10-day notice of reduction period.

b) When the child becomes covered by private major medical (see OAR 461-135-1100 for a definition of private major medical) and the insurance is not under contract to OPHP.
c) Upon becoming a resident of another state.

d) When the family does not pay their share of the HKC insurance premium.

e) When OPHP determines the child no longer qualifies for enrollment through OPHP.

f) When the department determines the child does not meet the requirements for eligibility, including, but not limited to, failure to re-enroll before the end of the eligibility period.

After determining eligibility

After making the eligibility decision, HKC cases must be transferred to Branch 5503:

- Please transfer the KC3, KCA or KCE CM system case to the OHP Statewide Processing Center (Branch 5503) online.

- Shuttle, UPS or mail a copy of the application to 2850 NE Broadway, Salem OR 97303. Be sure to use the HKC cover sheet. The cover sheet is available on the SSP medical tools Web site.

When to e-mail OPHP

- For HKC families with income from 201 percent of the federal poverty level (FPL) to 301 percent FPL, determine if the child is eligible for a KCA referral to OPHP. After coding the KCA/KCR referral on the CM system, send an e-mail to INFO, OPHP in the following situations:
  - When the KCA child is not receiving private major medical but it is available.
  - When the child who is otherwise eligible to be referred as a KCA child is receiving private major medical but qualifies for a waiver of the two-month waiting period.

When sending e-mails to INFO, OPHP about Health Insurance, be sure to include the following information:

- Case number

- Case name

- Name and phone number of the insurance company, or, for employer sponsored insurance, the name and phone number of the employer

- The names of child(ren) that are or could be covered by the insurance
Note: The Info, OPHP e-mail process replaces the DHS 415H process for HKC clients. The DHS 415H is no longer faxed to OPHP. The DHS 415H is still completed and sent to HIG for Medicaid clients.

HKC CM System Coding

Overview

For more information about the HKC CM system coding requirements, see the SSP medical program Web site.

For all HKC referred children, regardless of the income or circumstances, do not use the “VP” or “CP” CM case status to determine if the child is receiving medical benefits. HKC referrals in “VP” or “CP” status do not mean the child is receiving any kind of medical.

If the child has been referred to OPHP for HKC, the child will have a KCA or KC3 case descriptor.

- KCA children are eligible for DHS medical program benefits. Their family’s income is 201 percent to 301 percent. Once OPHP enrolls the child with an insurance carrier or begins making ESI premium subsidy payments, the KCA case descriptor will automatically be updated to KCE (HKC enrolled) and a medical start date added or updated.

- KC3 children are not eligible for DHS medical program benefits. They may purchase health insurance, but must pay the full premium amount. DHS benefits must be ended when completing the referral to OPHP. The CM case will remain in “VP” status through the KC3 referral end date.

KCA (201 percent to 301 percent HKC referrals)

HKC clients eligible at the KCA level are DHS clients. Do not send them a denial or closure notice when converting to HKC.

- Enter the number in the need group (including unborns) in the #OHP field on the UCMS screen.

- Use the HPK income need/resource to list income amounts (instead of the HPI need/resource).

Use a KCA case descriptor and need/resource item to identify each child who is HKC eligible with income 201 percent to 301 percent.

- Once the KCA coding is added, the CM system will automatically refer the KCA child to OPHP. The CM case will display in VP status until the KC3 referral is closed. OPHP has 45 days from the date of the referral to work with the family and issue a subsidy payment.
**Note:** *KCA children referred to OPHP may not have a medical start date on CMUP. The only time a KCA child will have a medical start date on CMUP is if the child is already receiving medical benefits through another program before the referral is made.*

- For the KCA need/resource end date, use the month in which the 10-day notice period ends after the 45-day period.

**Example:** A decision to refer to OPHP is made on April 15, 2010. Count 45 days from April 15 and add time for a 10-day notice. In this example the KCA end date is 06/10.

- If the KCA referred child is already receiving OHP Plus benefits, add the BED code as needed to keep the benefits open until OPHP issues HKC benefits. Match the BED end date to the KCA end date.

Use a KCR need/resource to identify each KCA referred child.

- The KCR end date is 12 months from the referral date.

**Example:** The decision is made April 15, 2010 to refer a KCA child to OPHP. The KCR end date is 04/2011.

**Note:** *KCA-referred children are eligible for a DHS medical program. Do not send them a denial notice. Also, the CM system will automatically send a referral notice. If the child is BED coded, the computer will add the reduction information to the referral notice. No 10-day notice of reduction is required.*

**Employer Sponsored Insurance coding:**

If the family has employer sponsored insurance available for the KCA child but the child is not receiving the insurance:

- Add an ESP need/resource item with a continuous date (ESP C) for each child with the available coverage. (Consider the insurance available even if it is not the employer’s open enrollment period).

**KC3 (301 percent and above HKC referrals):**

- Enter the number in the need group (including unborns) in the #OHP field on the UCMS screen.

- Use the HPK income need/resource to list income amounts (instead of the HPI need/resource). If the family is eligible for KC3 because the family is self-employed and the business entity income is $10,000 or higher, enter nines (9999) as the HPK income amount.

Use a KC3 case descriptor and need/resource item to identify each child who is HKC eligible with income 301 percent and above.
HKC children with family income at or above 301 percent are not DHS medical program clients. Families with children receiving DHS medical program benefits must be sent the CMCNSUB closure notice and a DHS 462A notice. Families with children who are not currently receiving DHS medical program benefits must be sent a CMDNSUB denial notice and a DHS 462A notice.

- Use a KC3 case descriptor and need/resource item for each child needing referral at 301 percent or above.

- For the KC3 need/resource end date, use the month after the referral was made. The CM case will display in VP status until the KC3 referral is closed.

- If the children are currently receiving DHS medical benefits, enter a COMPUTE action and end benefits the end of the month after the 10-day notice (and DHS 462A) is sent. You might need to wait until after the CM system compute deadline before adding the KC3 referral.

**Note:** *KC3-referred clients are not eligible for any DHS medical program. Do not forget to send them a closure or denial notice with the DHS 462A notice. No notice is required for the KC3-referred children. The CM system will automatically send a referral notice.*

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Filing Group; HKC, OHP: 461-110-0400
Periodic Redeterminations; Not EA, ERDC, EXT, OHP, REF, REF&M, SNAP or TA-DVS: 461-115-0430
Required Verification; BCCM, HKC, MA, MAF, OHP, SAC: 461-115-0705
Specific Requirement; OHP: 461-135-1100
Specific Requirements; Healthy KidsConnect (HKC): 461-135-1101
Concurrent and Duplicate Program Benefits: 461-165-0030
Changes That Must be Reported: 461-170-0011
Notice Situation; General Information: 461-175-0200