DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
Division of Social Services

14000 Medicaid General Eligibility Requirements

This section describes the general eligibility requirements for Medicaid.

17 DE Reg. 503 (11/01/13)

14100 General Application Information

The application will be the single, streamlined application for all insurance affordability programs developed by the Centers for Medicare and Medicaid Services (CMS) or an alternative single, streamlined application for all insurance affordability programs as approved by CMS.

For individuals applying, or who may be eligible, on a basis other than a determination based on the modified adjusted gross income (MAGI) methodologies described in Section 16000, the agency will use:

- a single, streamlined application and supplemental forms to collect the additional information needed, or
- an application designed specifically to determine eligibility on a basis other than MAGI.

The application may be submitted via the Internet web site established by the Federally Facilitated Marketplace (FFM), via the agency's Application for Social Service and Internet Screening Tool (ASSIST) self-service Internet web site, by telephone, via mail, in person with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act (ADA), and through other commonly available electronic means.

The FFM is a competitive marketplace for individuals and small employers to directly compare available health insurance options. The FFM will conduct basic screening and an assessment for potential Medicaid eligibility and transmit the information provided on the application to the agency for an eligibility determination as described in Section 14100.8 Coordination of Eligibility and Enrollment with Other Insurance Affordability Programs.

The application must be signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission are accepted.

When an application is completed online, the date of application is the date the application is submitted online. The date of application for a paper application will be the date of receipt in an agency office or the date of the postmark if received via the United States Postal Service (USPS). The application filing date is used to determine the earliest date for which Medicaid can be effective. Medicaid eligibility is effective the first day of the month if the individual was eligible at any time during that month provided the individual was a Delaware resident on the first of the month. If not a Delaware resident on the first of the month, Medicaid will be effective the date the individual became a Delaware resident.

Assistance will be provided to any individual seeking help with the application or renewal process in person, over the telephone, online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

17 DE Reg. 503 (11/01/13)

14100.1 Authorized Representatives

Applicants and beneficiaries are permitted to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. The designation must be in writing, including the applicant's signature, and is permitted at the time of application and at other times.

Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary. The authorized representative must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

The agency will accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission. Designation of authorized representatives will be accepted via ASSIST self-service web site, by telephone, via mail, in person, and through other commonly available electronic means.

Representatives may be authorized to:

- assist the individual in completing and submitting an application, verification, or other documentation;
- sign an application on the applicant's behalf;
- complete and submit a renewal form;

- receive copies of the applicant or beneficiary's notices and other communications from the agency; and/or
- act on behalf of the applicant or beneficiary in any other matters with the agency.

The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency the representative is no longer authorized to act on his or her behalf, or there is a change in the legal authority upon which the individual or organization's authority was based. This notification to the agency must be in writing and should include the individual's or authorized representative's signature as appropriate.

As a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization must sign an agreement that he or she will adhere to the regulation in:

- 42 CFR part 431, subpart F (relating to confidentiality of information);
- 45 CFR 155.260(f) (relating to confidentiality of information);
- 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf); and
- other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

17 DE Reg. 503 (11/01/13)

14100.2 Protected Filing Date

An individual's application filing date may be established based on either a written statement or an oral inquiry about Medicaid eligibility. An oral inquiry is a discussion about Medicaid eligibility for a specific person that results in a request for Medicaid. An oral inquiry must be documented when received. An oral inquiry or a written statement protects the filing date if a written application is completed and received in a DSS office within 30 days from the date of inquiry. When an application is received in the mail, the date of the postmark is considered the date of receipt. A postmark is the U.S. Postal Service mark stamped on a piece of mail canceling the postage stamp and recording the date and place of sending. An oral inquiry or written statement protects the filing date if an application is received within 30 days from the date of the inquiry.

17 DE Reg. 503 (11/01/13)

14100.3 Interview Requirement for Some Eligibility Groups

An in-person interview is not required for any eligibility group subject to the modified adjusted gross income (MAGI)-based methodologies described in Section 16000.

An in-person interview is not required for Long Term Care eligibility determinations. SEE SECTION 20101 - Application Process - Long-Term Care Services.

17 DE Reg. 503 (11/01/13)

22 DE Reg. 66 (07/01/18)

14100.4 Disposition of Applications

The agency must include in each applicant's case record facts to support the agency's decision on the individual's application. The agency must dispose of each application by a finding of eligibility or ineligibility, unless there is:

a) an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision;

b) a supporting entry in the case record that the applicant has died; or

c) a supporting entry in the case record that the applicant cannot be located.

An application must be reinstated effective as of the date the application was first received by the Federally Facilitated Marketplace (FFM) in cases where the individual:

a) submitted an application via the FFM and is assessed as not potentially eligible for Medicaid;

b) withdrew the application for Medicaid; and

c) is assessed as potentially eligible for Medicaid by the FFM appeals entity.

All applicants will receive a notice of acceptance or denial.

17 DE Reg. 503 (11/01/13)

14100.5 Determination of Eligibility

A determination of eligibility includes:

a) an approval or denial of eligibility for applicants;

b) a renewal of eligibility for beneficiaries;

c) a termination of eligibility for beneficiaries; and

d) a redetermination of eligibility between a regularly scheduled renewal based on a change reported or identified.

Each applicant or beneficiary who meets the non-financial eligibility requirements will have a determination of financial eligibility based on MAGI methodology. For an applicant or beneficiary found not eligible based on MAGI methodology and who has been identified on the application or renewal form as potentially eligible on a MAGI-excepted basis, a determination of eligibility will be made on such basis. In addition, an individual may request a determination of eligibility on a basis other than MAGI.

The agency will consider all categories of eligibility prior to a termination of eligibility. For individuals determined ineligible for Medicaid, the agency will determine potential eligibility for other insurance affordability programs in accordance with Section 14100.8 Coordination of Eligibility and Enrollment with Other Insurance Affordability Programs.

17 DE Reg. 503 (11/01/13)

14100.5.1 Timely Determination of Eligibility

The following Federal standards have been established for determining eligibility and informing applicants of the decision:

a. Ninety days (90) for applicants who apply for Medicaid on the basis of disability. This includes long term care and Children's Community Alternative Disability Program.

b. Forty-five (45) days for all other applicants.

The standards cover the period from the date of application with the agency or the date the application is transferred via the Federally Facilitated Marketplace (FFM) to the date the agency notifies the applicant of its decision.

The standards must be met except in unusual circumstances, such as:

a. A decision cannot be made because the applicant, his representative or his physician delays or fails to take a required action.

b. There is an administrative or other emergency beyond the Division's control.

The time standards must not be used as a waiting period before determining eligibility or as a reason for denying eligibility (because a decision has not been reached within the required time). Decision on applications should be made as quickly as possible, but if the final determination does not fall within the prescribed limits, the record must have documentation of the reasons for delay.

17 DE Reg. 503 (11/01/13)

17 DE Reg. 731 (01/01/14)

14100.6 Annual Renewal of Eligibility

The eligibility of Medicaid beneficiaries must be renewed once every twelve (12) months and no more frequently than once every twelve (12) months. The agency will redetermine eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's record or other more current information available to the agency. Information available to the agency includes but is not limited to information accessed through the electronic data sources described in DSSM 14800 - Verifications of Factors of Eligibility.

If the agency is able to renew eligibility based on the available information, the agency will notify the individual of:

- the eligibility determination and the information used for the determination; and
- the individual's responsibility to inform the agency if any of the information contained in the agency's notice is inaccurate. The individual may report this information via the agency's Application for Social Service and Internet Screening Tool (ASSIST) self-service Internet web site, by telephone, via mail, in person with reasonable accommodations for those with disabilities as defined by the Americans with Disabilities Act (ADA), and through other commonly available electronic means.

If the agency cannot renew eligibility as described above, the agency will provide the individual with a pre-populated renewal form. The pre-populated renewal form will contain information available to the agency about factors of eligibility. The renewal form will also include basic screening questions necessary to indicate potential eligibility on a basis other than modified adjusted gross income (MAGI).

The individual will be given thirty (30) days from the date of the renewal form to respond. The individual must provide any additional information requested and sign and return the renewal form. The request for additional information from the individual will be limited to only the information needed to renew eligibility. The individual may return the additional information and the renewal form through any of the submission modes described above.

If the individual does not respond to the renewal form and provide the additional information requested and eligibility is terminated on that basis, eligibility can be reconsidered if the individual responds within four months after the date of termination. The individual is not required to submit a new application. Coverage will extend back to the date of termination provided the individual is found eligible.

The agency will consider all categories of eligibility prior to a termination of eligibility as described in DSSM 14100.5 -

Determination of Eligibility.

9 DE Reg. 774 (11/01/05)
17 DE Reg. 731 (01/01/14)

14100.7 Fair Hearings

A fair hearing is an administrative hearing held in accordance with the principles of due process. An opportunity for a fair hearing will be provided, subject to the provisions in policy at DSSM Fair Hearing Section. Any individual who is dissatisfied with a decision of the Division of Social Services may request a fair hearing. See DSSM Fair Hearing Section for policies covering fair hearings.

14100.8 Coordination of Eligibility and Enrollment with Other Insurance Affordability Programs

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise.

"**Coordinated content**" means information included in an eligibility notice regarding the transfer of the individual's or households' electronic account to the Federally Facilitated Marketplace (FFM) for a determination of eligibility for another insurance affordability program.

"**Electronic account**" means an electronic file that includes all information collected and generated by the agency regarding each individual's Medicaid eligibility and enrollment including any information collected or generated as part of the agency fair hearing process or the FFM appeals process.

"**Insurance affordability program**" means a program that is one of the following:

1) Medicaid
2) Delaware Healthy Children Program
3) a State basic health program established under section 1331 of the Affordable Care Act
4) a program that makes available coverage in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals
5) a program that makes available coverage in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.

"**Secure electronic interface**" means an interface which allows for the exchange of data between Medicaid and other insurance affordability programs and adheres to the requirements in 42 CFR Part 433 subpart C.

17 DE Reg. 503 (11/01/13)

14100.8.1 Transfer from Other Insurance Affordability Programs to the State Agency

For individuals who have been assessed by the FFM (including as a result of a decision made by the FFM appeals entity) as potentially Medicaid eligible the agency must:

- accept, via secure electronic interface, the electronic account for the individual and notify the FFM of the receipt of the electronic account;
- not request information or documentation from the individual provided in the individual's electronic account;
- promptly and without undue delay, determine the Medicaid eligibility of the individual without
- requiring submission of another application; and
- notify the FFM of the final determination of the individual's eligibility or ineligibility for Medicaid.

17 DE Reg. 503 (11/01/13)

14100.8.2 Evaluation of Eligibility for Other Insurance Affordability Programs

For individuals who submit an application; return a renewal form; or whose eligibility is being redetermined due to a change in circumstances; and who are found ineligible for Medicaid, the agency will:

- promptly and without undue delay, determine potential eligibility for, and as appropriate, transfer via a secure electronic interface the individual's electronic account to the FFM, and
- include coordinated content in the notice of denial or termination of Medicaid eligibility.

17 DE Reg. 503 (11/01/13)

14100.8.3 Individuals Undergoing a Medicaid Eligibility Determination on a Basis other than MAGI

For individuals with household income greater than the applicable MAGI standard and for whom the agency is

determining eligibility on another basis, the agency must promptly and without undue delay:

- determine potential eligibility for, and as appropriate, transfer via secure electronic interface the individual's electronic account to the FFM;
- notify the FFM that the individual is not eligible based on MAGI, but a final determination on a non-MAGI basis is still pending; and
- notify the FFM of the agency's final determination of eligibility or ineligibility.

17 DE Reg. 503 (11/01/13)

14105 Social Security Number

Each individual applying for Medicaid, except as provided in this section, must furnish his or her Social Security number (SSN) as a condition of eligibility. If the individual cannot furnish a SSN, he or she must provide proof of an application for a SSN with the Social Security Administration (SSA). The agency will assist the applicant with the completion of an application for a SSN.

The SSN furnished will be verified with the Social Security Administration (SSA) via Federal Data Services Hub (FDSH) in accordance with Section 14800 Verifications of Factors of Eligibility. Eligibility will not be denied or delayed pending the issuance or verification of the SSN.

An individual whose income will be considered when determining eligibility for an applicant will be asked to furnish his or her SSN on the application. When the SSN of a financially responsible individual is voluntarily furnished, the SSN will be verified with SSA via the FDSH.

17 DE Reg. 503 (11/01/13)

14105.1 Exception to Furnish a Social Security Number (SSN)

The requirement to furnish a SSN does not apply to an individual who:

- is not eligible to receive a SSN;
- does not have a SSN and may only be issued a SSN for a valid non-work reason;
- refuses to obtain a SSN because of well-established religious objections; or
- is an infant under age one.

17 DE Reg. 503 (11/01/13)

14110 State Residency

An applicant or beneficiary must be a Delaware resident.

17 DE Reg. 503 (11/01/13)

14110.1 Definitions

The following words and terms, when used in the context of these policies, will have the following meaning unless the context clearly indicates otherwise:

Per 42 CFR 435.403(b), "**Institution**" has the same meaning as Institution and Medical Institution as defined in 42 CFR 435.1010. For purposes of state placement, the term also includes foster care homes, licensed as set forth in 45 CFR 1355.20, and providing food, shelter, and services to one or more persons unrelated to the proprietor.

Per 42 CFR 435.403(c), an individual is "Incapable of indicating intent" if the individual –

a) Has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Delaware Division of Developmental Disabilities;
b) Is judged legally incompetent; or
c) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the State in the field of intellectual disability.

17 DE Reg. 503 (11/01/13)

23 DE Reg. 303 (10/01/19)

14110.2 Placement by State in an Out-Of-State Institution

(42 CFR 435.403 (e))

An individual who is placed in an institution in another State by a Delaware agency including an entity recognized under State law as being under contract with the State for such purposes is considered a Delaware resident. The State arranging

or actually making the placement is considered as the individual's State of residence. Any action beyond providing information to the individual and the family constitutes arranging or making a State placement.

17 DE Reg. 503 (11/01/13)

23 DE Reg. 303 (10/01/19)

14110.3 Actions which do not Constitute State Placement
(42 CFR 435.403 (e))

The following actions do not constitute State placement:

a. Providing basic information to the individual about another State's Medicaid program and information about the availability of services and facilities in another State.

b. Assisting an individual in locating an institution in another State, provided the individual is capable of indicating intent and independently decides to move.

c. When a competent individual leaves the facility in which he/she is placed by State, the individual's State of residence for Medicaid purposes is the State where the individual is physically located.

17 DE Reg. 503 (11/01/13)

23 DE Reg. 303 (10/01/19)

14110.4 Lack of Appropriate Facility
(42 CFR 435.403 (e))

Where a placement is initiated by a State because the State lacks a sufficient number of appropriate facilities to provide services to its residents, the State making the placement is the individual's State of residence.

17 DE Reg. 503 (11/01/13)

23 DE Reg. 303 (10/01/19)

14110.5 [Reserved]

23 DE Reg. 303 (10/01/19)

14110.6 Individuals Receiving a State supplementary payment (SSP)
Per 42 CFR 435.403(f)

Individuals of any age who are receiving an SSP, the State of residence is the State paying the SSP.

23 DE Reg. 303 (10/01/19)

14110.7 Individuals Receiving Title IV-E Payments
Per 42 CFR 435.403(g)

Individuals of any age who are receiving Federal payments for foster care or adoption assistance under title IV-E of the Social Security Act, the State of residence is the State where the child lives.

23 DE Reg. 303 (10/01/19)

14110.8 Individuals Under Age 21
42 CFR 435.403(i)

For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under title IV-E of the Act, as addressed 14110.7 of this section, and is not receiving a State supplementary payment, as addressed in paragraph 14110.6 of this section, the State of residence is as follows:

a) For an individual who is capable of indicating intent and is married or emancipated from his or her parent, and is not residing in an institution, the State of residence is where the individual is living; and

- intends to reside including without a fixed address, or
- has entered the state with a job commitment or seeking employment (whether or not currently employed).

b) For an individual not described in a) and not living in an institution, the State of residence is:

- the state where the individual resides including without a fixed address; or
- the State of residency of the parent or caretaker, in accordance with 14110.9 of this section, with whom the individual resides.

c) For an institutionalized individual who is neither married nor emancipated, the State of residence is:
- the parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or
- the parent's or legal guardian's current State of residence if the individual is institutionalized in that same State (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or
- the State of residence of the individual who files an application is used if the individual has been abandoned by the parents (including deceased parents), there is no legal guardian, and is institutionalized in that state.

17 DE Reg. 503 (11/01/13)
23 DE Reg. 303 (10/01/19)

14110.8.1 Prohibitions

[Repealed, effective October 11, 2019.]
23 DE Reg. 303 (10/01/19)

14110.8.2 Exceptions

[Repealed, effective October 11, 2019.]
15 DE Reg. 362 (09/01/11)
23 DE Reg. 303 (10/01/19)

14110.9 Individuals Age 21 and Over
42 CFR 435.403(h)

For an individual over age 21 who is not eligible for Medicaid based on receipt of assistance under title IV-E of the Act, as addressed 14110.7 of this section, and is not receiving a State supplementary payment, as addressed in paragraph 14110.6 of this section, the State of residence is as follows:

a) For an individual not residing in an institution, the State of residence is the state where the individual is living and:
- intends to reside including without a fixed address; or
- has entered the state with a job commitment or seeking employment (whether or not currently employed).

b) For an individual not residing in an institution and who is not capable of stating intent, the State of residence is the state where the individual is living.

c) For any institutionalized individual who became incapable of indicating intent before age 21, the State of residence is:
- That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate States (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or
- The parent's or legal guardian's State of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's); or
- The current State of residence of the parent or legal guardian who files the application if the individual is institutionalized in that State (if a legal guardian has been appointed and parental rights are terminated, the State of residence of the guardian is used instead of the parent's).
- The State of residence of the individual or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that State.

d) For any institutionalized individual who became incapable of indicating intent at or after age 21, (irrespective of any type of guardianship) the State of residence is the state in which the individual is physically present, except where another state makes a placement.

e) For any other institutionalized individual, the State of residence is the state where the individual is living and intends to reside.

17 DE Reg. 503 (11/01/13)
23 DE Reg. 303 (10/01/19)

14110.10 Specific Prohibitions for Denial or Termination of Eligibility
42 CFR 435.403(j); 42 CFR 435.956(c)(2)

Per 42 CFR 435.956(c)(2), Evidence of immigration status may not be used to determine that an individual is not a State resident.

A State cannot deny Medicaid eligibility to otherwise qualified resident of the State because:

a) The individual's residence is not maintained permanently or at a fixed address.
b) The individual has not resided in the State for a specific period of time; or
c) An institutionalized individual did not establish residence in the community prior to admission to an institution.

A State cannot terminate Medicaid eligibility for an otherwise qualified resident of the State due to temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.

A State cannot wait to approve Medicaid eligibility in situations where the individual has moved to Delaware from another State and the Medicaid case is still open in the former State. The individual is no longer a resident of the former State and is ineligible in that State. The case may not be closed yet due to administrative processes.

17 DE Reg. 503 (11/01/13)
23 DE Reg. 303 (10/01/19)

14110.11 Exceptions to General Residency Rules
When the following exists, it supersedes the general residency rules:

a) When two or more States cannot resolve which State is the State of residence, the State in which the individual is physically located is the State of residence.

17 DE Reg. 503 (11/01/13)
23 DE Reg. 303 (10/01/19)

14120 Inmate of a Public Institution

Statutory Authority
Patient Protection and Affordable Care Act (ACA, P.L.111-148, as amended)

Inmates of a public institution who are held involuntarily may be enrolled in Medicaid if otherwise eligible, but Medicaid may not provide coverage for most services while the individual is detained. The inmate may be eligible for Medicaid coverage of services as an inpatient in a medical institution if admitted to the medical institution for more than 24 hours.

An inmate of a public institution is a person who is living in a public institution. A public institution is a facility that is under the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This control can exist when a facility is actually an organizational part of a governmental unit or when a governmental unit exercises final administrative control, including ownership and control of the physical facilities and grounds used to house inmates. Administrative control can also exist when a governmental unit is responsible for the ongoing daily activities of a facility; for example, when facility staff members are government employees or when a government unit, board, or officer has final authority to hire and fire employees. Privately supported institutions that are not under the control of a governmental unit do not meet the definition of a public institution.

An individual is an inmate and is not eligible when he or she is serving time for a criminal offense or is confined involuntarily awaiting trial, criminal proceedings, penal dispositions, or other involuntary detainment determinations and is living in:

a. State or Federal prison
b. jail
c. a detention facility
d. a wilderness camp under government control

e. a halfway house under government control

f. any penal facility

The following individuals are not inmates of a public institution and may be eligible:

1. An individual who is voluntarily living in a public institution after his or her case has been adjudicated and other living arrangements are being made (such as transfer to a community residence).
2. An individual who is sent to a privately supported institution as an alternative to a detention or prison sentence.
3. Infants living with the inmate in the public institution.
4. Parolees.
5. Probationers.
6. Individuals living in a halfway house that is not under governmental control.

26 DE Reg. 212 (09/01/22)

14300 Citizenship and Alienage

Medicaid must be provided to eligible citizens or nationals of the United States. An individual qualifies as a U.S. citizen if the person was born in the 50 states and District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, or Northern Mariana Islands. Nationals from American Samoa or Swain's Island are regarded as U.S. citizens for purposes of Medicaid eligibility. Children of a U.S. citizen who are born outside the U.S. may automatically be eligible for a Certificate of Citizenship.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193) enacted on August 22, 1996, significantly changed Medicaid eligibility for individuals who are not citizens of the U. S. The legislation revised the categories of noncitizens who may be determined eligible for Medicaid. The legislation identifies noncitizens as qualified aliens or nonqualified aliens. Medicaid eligibility for aliens is based on whether the alien is a qualified or nonqualified alien. The term nonqualified alien also includes illegal aliens.

All applicants, whether citizens or aliens, must meet the technical and financial eligibility criteria of a specific eligibility group such as SSI related group, AFDC related group, or poverty level related group. Not every alien, qualified or nonqualified, will be eligible for Medicaid or emergency services and labor and delivery only.

13 DE Reg. 1540 (06/01/10)
14 DE Reg. 1361 (06/01/11)

14310 Qualified Aliens

A qualified alien is:

a) An alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA).

b) A refugee who is admitted to the United States under §207 of the INA.

c) An alien who is granted asylum under §208 of the INA.

d) An alien whose deportation is being withheld under §243(h) of the INA or §241(b)(3) of the INA.

e) An alien who is paroled into the United States under §212(d)(5) of the INA for a period of at least 1 year.

f) An alien granted conditional entry pursuant to §203(a)(7) of the INA as in effect before April 1, 1980.

g) Honorably discharged veterans and aliens on active duty in the U.S. armed forces and the spouse or unmarried dependent children of a veteran or active duty serviceman. The discharge must not be due to alien status and the active duty status must not be for training. For example, the 2 weeks of active duty training usually required of members of the National Guard does not meet the definition of active duty. Hmong and other Highland Lao veterans who fought on behalf of the Armed Forces of the U.S. during the Vietnam conflict and who have lawfully been admitted for permanent residence are considered veterans.

h) An alien granted status as a Cuban and Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980).

i) An alien admitted to the U.S. as an Amerasian immigrant pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988.

j) Aliens who have been subjected to battery or extreme cruelty and who meet certain criteria, including an alien whose child has been battered or an alien child whose parent has been battered.

k) An American Indian born in Canada who is at least one-half American Indian blood and to whom the provisions of §289 of the INA apply or who is a member of an Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act.

l) Victims of trafficking under the Trafficking Victims Protection Act of 2000 including certain family members of victims of a severe form of trafficking.

m) Iraqi and Afghan special immigrants under The Department of Defense Appropriations Act of 2010. These immigrants are treated in the same manner as refugees.

13 DE Reg. 1540 (06/01/10)

14310.1 Five Year Bar

Unless specifically exempt, qualified aliens who enter the U.S. on or after August 22, 1996, are subject to a five-year bar from Medicaid. While subject to the five-year bar from full Medicaid, a qualified alien may be eligible for emergency services and labor and delivery only.

13 DE Reg. 1540 (06/01/10)

14310.2 Aliens Exempt from Five Year Bar

The following qualified aliens are exempt from the five-year bar:

- Refugees (§207 of INA)
- Asylees (§208 of INA)
- Aliens who have had deportation withheld under §243(h) or §241(b)(3) of the
- INA
- Honorably discharged veterans and aliens on active duty in the U.S. armed forces
- and the spouse or unmarried dependent children of a veteran or active duty serviceman.
- Cuban and Haitian entrants
- Amerasians
- An American Indian born in Canada, Mexico or who is a member of an Indian
- tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act
- Victims of trafficking
- Iraqi and Afghan special immigrants
- Legal permanent residents (LPR) who first entered the U.S. under an exempt
- category (such as refugee, asylee, Cuban/Haitian entrant) and later converted to LPR

In addition, title IV-E Foster Children and Adoption Assistance children may be found eligible for Medicaid regardless of the date of entry provided the foster or adoptive parent of the child is also a qualified alien or a citizen. The IV-E agency is responsible for making that determination about the parent. If a IV-E payment is being made on behalf of the child, then the child is deemed eligible for Medicaid.

13 DE Reg. 1540 (06/01/10)

14310.3 Date of Entry before August 22, 1996

An alien who entered the U.S. before August 22, 1996, and obtained qualified alien status before that date, may be found eligible for full Medicaid benefits.

An alien who entered the U.S. before August 22, 1996, but obtained qualified alien status on or after that date, is not subject to the five-year bar provided the alien remained continuously present in the U.S. from the latest date of entry prior to August 22, 1996, until becoming a qualified alien. This also applies to aliens who entered the U.S without proper documentation or those who overstayed their visa.

Any single absence from the U.S. of more than 30 days, or a total aggregate of absences of more than 90 days, is considered to interrupt continuous presence. For most legal entrants, the United States Citizenship and Immigration Services (USCIS) maintains a record of arrivals to and departures from the U.S. Verification of continuous presence may be obtained by filing Form G-845 and Form G-845-Supplement with the USCIS. For some legal entrants, such as Canadian and Mexican border crossers, and for illegal entrants, the USCIS does not maintain an arrival and departure record. These aliens must provide proof of continuous presence, such as tax returns, employment records, or rent receipts.

Once an immigrant has obtained qualified alien status, he or she does not have to remain continuously present in the U.S.

13 DE Reg. 1540 (06/01/10)

14310.4 Date of Entry on or after August 22, 1996

An alien who entered the U.S. on or after August 22, 1996, is not eligible for full Medicaid benefits for five years. The alien may be eligible for emergency services and labor and delivery only. The five-year bar begins on the date the immigrant obtains qualified alien status.

13 DE Reg. 1540 (06/01/10)

14320 Legally Residing Nonqualified Aliens

These are aliens who do not meet the definition of a qualified alien. Individuals formerly known as PRUCOL are now considered nonqualified aliens. Nonqualified aliens have to provide a Social Security Number (SSN) if one is available, or apply for a SSN if the applicant does not have one.

Legally residing nonqualified aliens include the following:

1. A citizen of a Compact of Free Association State (Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.

2. An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:

a) an individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the INA

b) an individual currently under Temporary Protected Status pursuant to section 244 of the INA and pending applicants for Temporary Protected Status who have been granted employment authorization

c) a family unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554

d) an individual currently under Deferred Departure pursuant to a decision made by the President

e) an individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status.

3. An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:

a) a parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA

b) a fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA

c) a religious worker under section 101(a)(15)(R)

d) an individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA

e) a battered alien under section 101(a)(15)(U)(see also section 431 as amended by PRWORA)

f) an individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA

4. An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission.

5. An alien who has been paroled into the U.S. pursuant to section 212(d)(5) of the INA for less than one year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings.

6. Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24).

7. Aliens currently in deferred action status.

8. A pending applicant for asylum under section 208(a) of the INA or for withholding of removal under section 241(b)(3) of the INA or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days.

9. An alien who has been granted withholding of removal under the Convention Against Torture.

10. A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA.

11. An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e).

12. An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

13 DE Reg. 1540 (06/01/10)
14 DE Reg. 654 (01/01/11)

14320.1 Medicaid Eligibility for Legally Residing Nonqualified Aliens

Legally residing nonqualified aliens may be eligible for emergency services and labor and delivery only. Legally residing nonqualified aliens are not eligible for any long term care Medicaid program.

13 DE Reg. 1540 (06/01/10)

14330 Illegally Residing Nonqualified Aliens

The term nonqualified aliens also includes aliens who are illegally residing in the U.S. These aliens were never legally admitted to the U.S. for any period of time or were admitted for a limited period of time and did not leave the U.S. when the period of time expired. Aliens who are illegally residing in the U.S. do not have to provide a SSN.

13 DE Reg. 1540 (06/01/10)

14330.1 Medicaid Eligibility for Illegally Residing Nonqualified Aliens

Illegally residing nonqualified aliens may be eligible for emergency services and labor and delivery only. Illegally residing nonqualified aliens are not eligible for any long term care Medicaid program.

13 DE Reg. 1540 (06/01/10)

14340 Ineligible Aliens

[Repealed, effective October 11, 2019.]
13 DE Reg. 1540 (06/01/10)
23 DE Reg. 303 (10/01/19)

14340.1 Medicaid Eligibility for Certain Ineligible Aliens

[Repealed, effective October 11, 2019.]
13 DE Reg. 1540 (06/01/10)
23 DE Reg. 303 (10/01/19)

14350 Legal Immigrant Pregnant Women and Children under age 21

Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) authorizes coverage under Medicaid or CHIP for certain alien pregnant women and children who are lawfully residing in the United States and are otherwise eligible. Delaware will cover these certain alien pregnant women under Medicaid and will cover these certain alien children under Medicaid or CHIP. Eligibility under this section will be implemented with the earliest effective date of July 1, 2010. Children who are in one of the legal alien groups must have their immigration status verified at each annual redetermination. The documentation provided for the initial application may be used.

The alien groups who may be determined eligible under this section are:

1. An alien who is lawfully admitted for permanent residence under the INA, who entered the U.S. on or after August 22, 1996, and is subject to the five-year bar under PRWORA.

2. An alien who is paroled into the United States under §212(d)(5) of the INA for a period of at least 1 year who, entered the U.S. on or after August 22, 1996, and is subject to the five-year bar under PRWORA.

3. An alien granted conditional entry pursuant to §203(a)(7) of the INA as in effect before April 1, 1980, who entered the U.S. on or after August 22, 1996, and is subject to the five-year bar under PRWORA.

4. A citizen of a Compact of Free Association State (Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.

5. An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:

a) an individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the INA

b) an individual currently under Temporary Protected Status pursuant to section 244 of the INA and pending applicants for Temporary Protected Status who have been granted employment authorization

c) a family unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554

d) an individual currently under Deferred Departure pursuant to a decision made by the President

e) an individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status.

6. An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:

a) a parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA

b) a fiance´ of a citizen, as permitted under section 101(a)(15)(K) of the INA

c) a religious worker under section 101(a)(15)(R)

d) an individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA

e) a battered alien under section 101(a)(15)(U)(see also section 431 as amended by PRWORA)

f) an individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA

7. An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission.

8. An alien who has been paroled into the U.S. pursuant to section 212(d)(5) of the INA for less than one year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings.

9. Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24).

10. Aliens currently in deferred action status.

11. A pending applicant for asylum under section 208(a) of the INA or for withholding of removal under section 241(b)(3) of the INA or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days.

12. An alien who has been granted withholding of removal under the Convention Against Torture.

13. A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA.

14. An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e).

15. An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

13 DE Reg. 1540 (06/01/10)
14 DE Reg. 654 (01/01/11)

14360 State Funded Benefits

In State Fiscal Year 1998, (SFY 98), the Delaware legislature appropriated state only funds to provide coverage of full Medicaid benefits to certain legally residing noncitizens who are ineligible for full Medicaid benefits because of PRWORA. This did not include long term care services. Coverage for these aliens was subject to the availability of state funding. Effective July 1, 2011, state funded benefits are no longer available for these certain legally residing noncitizens. These aliens may be found eligible for emergency services and labor and delivery only.

13 DE Reg. 1540 (06/01/10)
14 DE Reg. 1361 (06/01/11)

14370 Coverage of Emergency Services and Labor and Delivery Only

Emergency services must be rendered in an acute care hospital emergency room or in an acute care inpatient hospital. Labor and delivery only services must be rendered in an acute care hospital emergency room, an acute care inpatient hospital, or a birthing center. The DMAP defines an emergency as:

- a sudden serious medical situation that is life threatening; or
- a severe acute illness or accidental injury that demands immediate medical attention or surgical attention; and
- without the treatment a person's life could be threatened or he or she could suffer serious long lasting disability.

Medically necessary physician (surgeon, pathologist, anesthesiologist, emergency room physician, internist, etc.) or midwife services rendered during an emergency service that meets the above criteria are covered. Ancillary services (lab, x-ray, pharmacy, etc.) rendered during an emergency service that meets the above criteria are also covered. Emergency ambulance services to transport these individuals to and from the services defined above are also covered.

Services not covered for aliens who are determined to be eligible for emergency services and labor and delivery only include but are not limited to:

- any service delivered in a setting other than an acute care hospital emergency room or an acute care inpatient hospital. Exception: labor and delivery services may be rendered in a birthing center.
- any service (such as pharmacy, transportation, office visit, lab or x-ray, home health) that precedes or is subsequent to a covered emergency service. Exception: ambulance transportation that is directly related to the emergency is covered.
- organ transplants
- long term care or rehabilitation care
- routine prenatal and post partum care

13 DE Reg. 1540 (06/01/10)
15 DE Reg. 1023 (01/01/12)

14380 Declaration of U.S. Citizenship and Satisfactory Immigration Status

As a condition of eligibility under section 1137(d) of the Act, an applicant must sign a written declaration under penalty of perjury stating if he or she is a citizen or national of the U.S. or an alien in satisfactory immigration status (qualified alien or alien in lawful status). This declaration is obtained as part of the application for Medicaid. In the case of a child or incompetent applicant, an adult must sign on the applicant's behalf.

If the applicant is not a citizen or national of the United States, qualified alien, or an alien in lawful status, the declaration of citizenship or satisfactory immigration status and verification of such status is not required. If the applicant will not sign the declaration, he or she may be found eligible for coverage of emergency services and labor and delivery only.

13 DE Reg. 1540 (06/01/10)

14390 Documentation of Citizenship and Identity or Alien Status

Applicants must provide documentation of citizenship and identity, qualified alien status, or lawful alien status.

Exception: The following groups of individuals are not required to provide documentation of citizenship and identity:

a) Individuals receiving SSI

b) Individuals entitled to or enrolled in any part of Medicare

c) Individuals receiving Social Security Disability Insurance benefits

d) Individuals who are recipients of foster care maintenance or adoption assistance payments under Title IV-E of the Act

e) Individuals who are in foster care and who are assisted under Title IV-B of the Act

f) Deemed newborns – a child born in the U.S. to a woman who was eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) on the date of the child's birth. This includes a retroactive determination of eligibility.

If the applicant will not provide evidence of alien status and does not allege qualified or lawful alien status, the applicant may be eligible for coverage of emergency services and labor and delivery only.

13 DE Reg. 1540 (06/01/10)

14390.1 Reasonable Opportunity to Provide Documentation of Citizenship and Identity or Alien Status

An applicant shall have a reasonable opportunity period of 90 days to obtain and provide proof of citizenship and identity, qualified alien status, or lawful alien status. The reasonable opportunity period begins on the date a written request for documentation is issued to the applicant.

Medicaid shall be approved to otherwise eligible applicants during the reasonable opportunity period. If the individual has not provided satisfactory documentation by the end of the reasonable opportunity period, eligibility will be terminated.

13 DE Reg. 1540 (06/01/10)

14400 Acceptable Evidence of U. S. Citizenship and Identity

Both citizenship AND identity can be verified by the Social Security Administration through the State Verification Exchange System (SVES). If verification cannot be obtained through SVES, verification of citizenship and identity must be obtained from original documents or certified copies from the issuing agency. Once documentation of citizenship and identity has been provided, it is not necessary to obtain documentation again.

The list below provides acceptable documentation for verifying citizenship and identity. There are four levels of verification listed in order of preference. If a higher level document is not available, a lower level may be used.

A. First level documentation of both citizenship AND identity

1. A U.S. passport. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity. Note: Spouses and

children were sometimes included on one passport through 1980. The citizenship and identity of the included person can be established when one of these passports is presented. U.S. passports issued after 1980 show only one person.

2. A Certificate of Naturalization (DHS Forms N–550 or N–570)

3. A Certificate of U.S. Citizenship (DHS Forms N–560 or N–561)

B. Second level documentation of citizenship

1. A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)).

2. A Certification of Report of Birth (DS–1350)

3. A Report of Birth Abroad of a U.S. Citizen (Form FS–240)

4. A Certification of birth issued by the Department of State (Form FS–545)

5. A U.S. Citizen I.D. card (I-197 or I-179)

6. A Northern Mariana Identification Card (I–873)

7. An American Indian Card (I–872)

8. A final adoption decree showing the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

9. Evidence of U.S. Civil Service employment before June 1, 1976

10. U.S. Military Record showing a U.S. place of birth. (DD–214 or similar official document showing a U.S. place of birth)

11. A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.

12. Child Citizenship Act - Obtain documentary evidence that verifies that at any time on or after February 27, 2001, the following conditions have been met: (i) at least one parent of the child is a U.S. citizen by either birth or naturalization and this has been verified; (ii) the child is under the age of 18; (iii) the child is residing in the U.S. in the legal and physical custody of the U.S. citizen parent; (iv) the child was admitted to the U.S. for lawful permanent residence and this has been verified; and (v) if adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 U.S.C. 1101(b)(1) pertaining to international adoptions (admission for lawful permanent residence as IR–3 or IR–4).

C. Third level documentation of citizenship

1. Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth. For children under age 16, the document must have been created near the time of birth or 5 years before the date of application. Do not accept a souvenir “birth certificate” issued by the hospital.

2. Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date and that indicates a U.S. place of birth. For children under age 16, the document must have been created near the time of birth or 5 years before the date of application. Life or health insurance records may show biographical information for the person including place of birth and can be used to establish U.S. citizenship when it shows a U.S. place of birth.

3. Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization.

4. Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

D. Fourth level documentation of citizenship

1. Federal or State census record showing U.S. citizenship or a U.S. place of birth. Census records from 1900 through 1950 contain certain citizenship information. The census record must also show the applicant's age.

2. One of the documents listed that shows a U.S. place of birth and was created at least 5 years before the application for Medicaid. For children under age 16, the document must have been created near the time of birth or 5 years before the date of application. This document must be one of the following and show a U.S. place of birth:

a) Seneca Indian tribal census record.

b) Bureau of Indian Affairs tribal census records of the Navajo Indians.

c) U.S. State Vital Statistics official notification of birth registration.

d) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth.

e) Statement signed by the physician or midwife who was in attendance at the time of birth

f) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

3. Institutional admission papers from a nursing facility, skilled care facility, or other institution created at least 5 years before the initial application date that indicates a U.S. place of birth. Admission papers generally show biographical information for the person including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

4. Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth. For children under age 16, the document must have been created near the time of birth or 5 years before the date of application. Medical records generally show biographical information for the person including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth. (Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.)

5. Written affidavit. Affidavits should only be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

a) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.

b) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

c) The persons making the affidavits must be able to provide proof of their own citizenship and identity.

d) If the individual making the affidavit has information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

e) The applicant or representative must make a separate affidavit explaining why the evidence does not exist or cannot be obtained.

f) The affidavits must be signed under penalty of perjury and need not be notarized.

E. Documentation of identity.

1. Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1). Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1).

a) Driver's license issued by a State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight, or eye color.

b) School identification card with a photograph of the individual.

c) U.S. military card or draft record.

d) Identification card issued by the Federal, State, or local government with the same information included on drivers' licenses.

e) Military dependent's identification card.

f) Certificate of Degree of Indian Blood, or other American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color.

g) U.S. Coast Guard Merchant Mariner card.

2. A cross match with Office of Vital Statistics.

3. Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third level evidence of citizenship. Such documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All documents used must contain consistent identifying information. These documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds/titles.

F. Special identity rules for children

For children under age 16, a clinic, doctor, hospital, or school record may be accepted. School records include nursery or daycare records and report cards if verified with the issuing school. If none of the above documents in the preceding groups are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent, guardian, or caretaker relative stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided. The affidavit is not required to be notarized. An affidavit for children under age 18 may be accepted when a school ID card or driver's license is not available.

G. Special identity rules for individuals with disabilities in institutional care facilities

An affidavit signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility.

13 DE Reg. 1540 (06/01/10)

14410 Acceptable Evidence of Qualified Alien Status

Documentation of alien status is issued by the U.S. Citizenship and Immigration Services (USCIS) of the Department of Homeland Security. Older documents were issued by the Immigration and Naturalization Service (INS).

Acceptable documentation of qualified alien status is listed below. The card should show the date of admission or date of entry into the United States.

A. Lawful Permanent Residents

Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

NOTE: USCIS has replaced Forms I-151, AR-3 and AR-3a. If a lawful permanent resident presents one of these old forms as evidence of status, contact USCIS using a G-845S and attach the old card.

B. Refugees

Form I-94 annotated with stamp showing entry as refugee under §207 of the Immigration and Naturalization Act (INA) and date of entry to the United States; Form I-688B annotated 274a.2(a)(3); I-766 annotated A3; or Form I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the U.S. However, for purposes of eligibility, the individual is still considered a refugee and it is important to check the coding on Form I-551 for codes RE-6, RE-7, RE-8, or RE-9.

C. Asylees

Form I-94 annotated with stamp showing grant of asylum under §208 of the INA; a grant letter from the Asylum Office of the USCIS; Form I-688B annotated 274a.12(a)(5); I-766 annotated A5; or an order of an Immigration Judge granting asylum. If the applicant provides a court order contact USCIS using a G-845S and attach a copy of the court order.

D. Alien who has had deportation withheld under §243(h) of the INA

Order of an Immigration Judge showing deportation withheld under §243(h) or §241(b)(3) and date of the grant; Form I-688B annotated 274a.12(a)(10); or I-766 annotated A10. If applicant provides a court order contact USCIS using G-845S and attach copy of court order.

E. Parolees

Form I-94 annotated with stamp showing grant of parole under §212(d)(5) of the INA and a date showing granting of parole for at least 1 year. Form I-688B annotated 274a.12(a)(4) or 274a.12(c)(11) or I-766 annotated A4 or C11 indicates status as a parolee but does not reflect the length of the parole period.

F. Conditional Entrant

Form I-94 annotated with stamp showing admission under §203(a)(7) of the INA, refugee-conditional entry; Forms I-688B annotated 274a.12(a)(3); or I-766 annotated A-3.

G. Evidence of Honorable Discharge or Active Duty Status

Discharge - a copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member. (Department of Defense Form 214)

Active Duty Military - a copy of the applicant's current orders showing the individual is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard or an active military identification card, DD Form 2. Full time National Guard duty is excluded.

H. Cuban and Haitian entrants

I-551 annotated CH6, CNP, CU6, CU7; I-688B annotated 274a.12(a)(4); I-94 annotated 212(d)(5)

I. Amerasian

I-94 annotated AM1, AM2, AM3; I-551 annotated AM1, AM2, AM3.

J. Battered Immigrant

In order to be a qualified alien based on battery or extreme cruelty, the alien must meet the following requirements:

1. the alien must not now be residing in the same household as the individual responsible for the battery or extreme cruelty

2. the alien or the alien's child has been battered or subjected to extreme cruelty in the U.S. by a spouse or parent of the alien, or by a member of the spouse's or parent's family residing in the same household as the alien, but only if the spouse or parent consents to or acquiesces in such battery or cruelty and, in the case of a battered child, the alien did not actively participate in the battery or cruelty

3. there is substantial connection between the battery or extreme cruelty and the need for the public benefit sought. There is a substantial connection under any one or more of the following circumstances:

a) Where the benefits are needed to enable the alien and/or the alien's child to become self-sufficient following separation from the abuser;

b) Where the benefits are needed to enable the alien and/or the alien's child to escape the abuser and/or the community in which the abuser lives, or to ensure the safety of the alien and/or his or her child from the abuser;

c) Where the benefits are needed due to a loss of financial support resulting from the alien's and/or his or her child's separation from the abuser;

d) Where the benefits are needed because the battery or cruelty, separation from the abuser, or work absence or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating to the battery or cruelty (such as child support or child custody disputes) cause the alien and/or the alien's child to lose his or her job or require the alien and/or the alien's child to leave his or her job for safety reasons;

e) Where the benefits are needed because the alien or his or her child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or cruelty;

f) Where the benefits are needed because the loss of a dwelling or source of income or fear of the abuser following separation from the abuser jeopardizes the alien's ability to care for his or her children (e.g. inability to house, feed, or clothe children or to put children into day care for fear of being found by the batterer);

g) Where the benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser;

h) Where the benefits are needed to provide medical care during an unwanted pregnancy resulting from the abuser's sexual assault or abuse of or relationship with the alien or his or her child; and/or to care for any resulting children; or

i) where medical coverage and/or health care services are needed to replace medical coverage or health care services the applicant or child had when living with the abuser.

4. the alien or alien's child must have a petition approved by or pending with USCIS under one of several subsections of the INA that sets forth a prima facie case for the status.

K. American Indian born in Canada or Mexico under section 289 of the INA or member of Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act

Form I-551 with the code S13; unexpired temporary I-551 stamp with code S13 in a Canadian passport or on Form I-94; satisfactory evidence of birth in Canada and a document that indicates the percentage of American Indian blood in the form of a birth certificate issued by the Canadian reservation or a record issued by the tribe; a membership card or other tribal document showing membership in the tribe that is on the list of recognized Indian tribes published annually by the Bureau of Indian Affairs in the Federal Register.

L. Victims of Trafficking

Form I-797 indicating Class T-1 Visa, T-2 (spouse), T-3 (child), T-4 (parent) or T-5 (unmarried sibling under age 18); letter of certification from the Office of Refugee Resettlement (ORR). Call the trafficking verification line at (202) 401-5510 to confirm the validity of the certification letter or similar letter for children and to notify ORR of the benefits for which the individual has applied.

M. Iraqi and Afghan special immigrants

Iraqi passport with an immigrant visa stamp SI1, SI2 (spouse), SI3 (unmarried child under age 21); an immigrant visa stamp SQ1, SQ2 (spouse), SQ3 (unmarried child under age 21); I-551 showing Iraqi nationality (or an Iraqi passport) with code S16 or SQ6, code S17 or SQ7 (spouse), code S19 or SQ9 (unmarried child under age 21).

13 DE Reg. 1540 (06/01/10)

14420 Verification of Alien Status

The Systematic Alien Verification for Entitlements (SAVE) is a program established by USCIS that provides a process to verify the immigration status of aliens who apply for benefits. The documents provided by an alien applicant as verification of immigration status must be authenticated by using SAVE.

Staff will institute primary verification to USCIS through the form "Record of Contact with ASVI Data Base" (SAVE-1). ASVI is the acronym for Alien Status Verification Index. A clear copy of the immigration document must be attached to the SAVE-1 form. If the response verifies alien status, the eligibility determination is completed using the information provided by USCIS.

If the response states institute secondary verification, staff will complete Form G-845 and attach a copy of the immigration document.

An alien registration number is required for both primary and secondary verifications. If the applicant provides an alien registration number but does not have the immigration document, complete Form G-845 including the alien registration number. If an applicant provides a receipt indicating that he or she has applied to USCIS for a replacement document, complete Form G-845 and attach a copy of the receipt.

13 DE Reg. 1540 (06/01/10)

14500 Criteria Affecting Specific Groups

Certain eligibility groups have requirements that include age, household composition/filing unit, and medical eligibility/ disability.

14510 Age

Some eligibility groups have certain age requirements. Refer to specific eligibility group for information specific to that program.

14520 Household Composition/Filing Unit

Generally, related applicants, their needs, income and resources are grouped together when a family applies for Medicaid. The requirements are specific to each eligibility group.

14530 Medical Eligibility/Disability

Certain eligibility groups require a medical professional to certify that an applicant meets the specific program definition of medical need or disability. Examples are:

- pregnant women must have proof of pregnancy

- children with a disability must meet disability and level of care requirements
- long term care applicants must meet level of care requirements

15 DE Reg. 202 (08/01/11)

14540 Estate Recovery Protections

Effective with dates of service on or after January 1, 2010, medical assistance for Medicare cost-sharing is protected from estate recovery for certain categories of individuals who, collectively, are known as dual eligibles.

The following categories of individuals are protected from estate recovery of Medicare cost-sharing:

a) Qualified Medicare Beneficiaries
b) Specified Low Income Medicare Beneficiaries
c) Qualifying Individuals
d) Qualified and Disabled Working Individuals
e) Qualified Medicare Beneficiaries with full Medicaid
f) Specified Low Income Medicare Beneficiaries with full Medicaid

Medicare cost-sharing includes payments of Part A and Part B premiums, deductibles, coinsurance, and copayments. The date of service for premiums is the date DMMA paid the premium. The date of service for deductibles, coinsurance, and copayments is the date the request for payment is received by DMMA. The protection from estate recovery for Medicare cost sharing applies to mandatory and optional services under the State plan including nursing facility, home and community-based services, and related prescription drugs and hospital services.

15 DE Reg. 84 (07/01/11)

14600 Third-Party Liability

Some Medicaid recipients are covered by other medical insurance plans. Examples of other resources are Medicare, employment related health insurance, Union Health & Welfare Funds, national Blue Cross and Blue Shield plans, Military Health Insurance For Active Duty, Retired Military, and their dependents, workmen's compensation, and no-fault automobile coverage. When a recipient receives payment from an insurance carrier, court settlement, etc. for any medical services paid by Medicaid, the recipient is obligated to reimburse the program for those related services. All such cases must be referred to the Third Party Liability Unit at the Medicaid State Office.

14610 Assignment Of Rights To Benefits

As a condition of eligibility, each legally able applicant and recipient must:

A. assign his or her rights and the rights of any other eligible individuals for whom the individual has the legal authority under State laws to assign such rights, to medical support or other third party payments to the agency. (for example, a parent assigns the rights of a child);

B. cooperate in establishing paternity and obtaining medical support unless there is a finding of good cause (pregnant and post partum women do not have to meet this requirement); and

C. cooperate, absent good cause, in identifying and providing information needed to pursue third parties who may be liable to pay for medical services covered by Medicaid.

14620 Rights Assigned

The applicant or recipient must make a written assignment assigning his or her rights to any medical support available under an order of a court or an administrative agency. He or she must also assign to Medicaid any third party payments for medical care and payments for any other eligible individual for whom he or she has the legal authority under State law to make an assignment.

14630 Cooperation In Establishing Paternity And Obtaining Support

The individual is required to cooperate in establishing the paternity of a child born out of wedlock for whom the individual can legally assign rights and in obtaining medical care support and medical care payments for himself/herself, as well as for any other person for whom the individual can legally assign rights. Exception: Pregnant and Post Partum women do not have to cooperate in establishing paternity and obtaining medical support.

14640 Identifying and Providing Third Party Information

The individual is required to cooperate in identifying and providing information to assist the state in pursuing any third party which may be liable to pay for care and services available under the state plan.

14650 Good Cause For Noncooperation

The requirements for cooperation may be waived if there is a determination of good cause. The determination of whether good cause exists is based on the factors established by the TANF/AFDC child support enforcement program at 45 CFR 232.40 - 232.49. Use similar procedures to make a determination of good cause for individuals other than a child excluding those applicable only to children.

14660 Denial Or Termination Of Eligibility

Individuals who fail to meet the assignment provisions including assignment of rights to benefits and cooperation must be denied Medicaid eligibility or have eligibility terminated if already receiving Medicaid. This includes individuals who refuse to assign his or her own rights or those of any other individual for whom he or she can legally make an assignment. Pregnant and postpartum women do not have to cooperate in establishing paternity and obtaining medical support.

Medicaid must be provided to any individual who cannot legally assign his or her own rights and is otherwise eligible for Medicaid, when the person who has the legal authority refuses to assign the eligible individual’s rights. For example, if a mother refuses to assign benefits for herself and her children, only the mother becomes ineligible for Medicaid. The children remain eligible. However, if a mother with a newborn refuses to assign rights or to cooperate, both the mother and the newborn are ineligible, since the newborn’s eligibility is dependent upon the mother’s eligibility. An application must be filed on behalf of the newborn to establish eligibility on his or her own behalf as a child.

14670 Payor Of Last Resort

Because other insurance is commonly available, the Federal Government as a way of saving taxpayers’ monies, has required by law THAT Medicaid be a payor of last resort.

Because Medicaid is a payor of last resort, it is especially important to screen patients for the existence of other health insurance coverage. Keep in mind that other insurance will usually pay more for the incurred charges than Medicaid, hence it is beneficial to always inquire thoroughly.

Although the Medicaid Program attempts to collect this information when a recipient becomes eligible, additional efforts in this area at redetermination should not only increase provider's payments, but decrease the expenditures of taxpayers' monies.

The usual elements that a financial social worker will need to obtain are: name, address, policy number of the insurance company, as well as the policy holders name, address, Social Security number, employer number and effective dates of coverage.

Medicaid will only pay a designated amount (which is usually lower than the amount billed) no matter what the provider charges. This payment has to be accepted in full by the provider and the client cannot be billed for any balance. Providers agree to accept our payment as payment in full when they sign a contract to enroll in the Medicaid Program. Any violations should be referred to the Surveillance and Utilization Review unit.

Clients can report loss of coverage or a change in benefit directly to the TPL unit via phone call. This unit also investigates and verifies potential coverage for Medicaid recipients.

14680 Third Party Liability Guide

To aid in turning up other possible sources of coverage, the following guide has been prepared.

IF YOU FIND:	THEN A CASE MEMBER MAY BE ELIGIBLE FOR:
Any case member is over 65 or blind or disabled	Medicare or Medicare Supplemental policies
A recipient, absent parent, step-parent, dependent child, new spouse or an absent parent, or anyone else who is legally or voluntarily responsible for a case member is EMPLOYED or a UNION MEMBER	Employment related health insurance
A case member, spouse of a case member, absent parent, or step-parent is ACTIVE DUTY MILITARY or a VETERAN	Military Health Insurance For Active Duty, Retired Military, and their dependents, VA Health coverage
Any case member has been in an accident or otherwise accidentally injured: INJURY/TRAUMA/ ACCIDENT	Workman's compensation, homeowners insurance, automobile insurance, liability insurance

14700 Assets

There are different types of income and resources which are counted and budgeted according to a specific Medicaid program's criteria.

14710 Income

Income is any payment from any source whether in money, goods or services; whether recurring or on a one-time basis. Gross income, net income, disregarded income, excluded income, earned and unearned income are defined in the policy of each specific program.

Income eligibility limits vary from program to program.

For each Medicaid eligibility group and for the Delaware Healthy Children Program, all wages paid by the U.S. Census Bureau for temporary employment related to Decennial Census activities are excluded in years in which there is a federal census.

12 DE Reg. 1416 (05/01/09)

14720 Resources

Resources vary from program to program. See specific program for limits. The term "resources" means things a person owns. It includes real estate and personal property, such as household goods, savings and checking accounts, stocks and bonds, life insurance, and other assets that can be applied to meeting a person's needs for food, clothing, or shelter.

14730 Accepting Other Benefits

As a condition of eligibility, applicants/recipients are required to take all necessary steps to obtain any income or resource benefits. Examples are annuities, pensions, retirement, disability and veteran's benefits to which they are entitled.

14800 Verifications of Factors of Eligibility

Regulatory Statute
42 CFR 435.948
42 CFR 435.949
42 CFR 435.952
42 CFR 435.956

Attestation will be accepted for most factors of eligibility at application, renewal, and for a change in circumstances. Attestation will be accepted by the individual; an adult who is in the applicant's household; an authorized representative; or if the individual is a minor or incapacitated someone acting responsibly for the individual. Certain factors of eligibility will be verified post-enrollment, post-renewal, and after a redetermination of eligibility due to a change in circumstances.

Verification will be obtained electronically using the Federal Data Services Hub (FDSH) and other electronic data sources. The FDSH is a service that enables access to multiple data bases via a single electronic transaction. Data will be available from the Social Security Administration (SSA), Department of Homeland Security (DHS), Internal Revenue Service (IRS), and Equifax Workforce Solutions (also known as TALX). TALX is a contracted service that verifies earned income as reported by employers. The agency will not be obtaining IRS data.

Other electronic data sources include the following:

- State Wage Information Collection Agency (SWICA)
- State Unemployment Compensation
- General Assistance Program
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Child Care Subsidy Program
- Office of Vital Statistics
- Department of Motor Vehicles
- Office of Child Support Enforcement
- Public Assistance Reporting Information System (PARIS).

Attestation will be accepted without post-enrollment verification for the following factors of eligibility:

- residency
- date of birth
- household composition
- household relationships
- application for other benefits
- pregnancy – unless other available information, such as a medical claim, is not reasonably compatible with such attestation.

Attestation will be accepted with post-enrollment verification for the following factors of eligibility:

- income
- Medicare.

Attestation will not be accepted and must be verified via the FDSH for the following factors of eligibility:

- citizenship and identity
- immigration status
- Social Security number (SSN).

If citizenship and immigration status cannot be verified via the FDSH, the individual will be provided with a 90-day reasonable opportunity period to submit other documentation and may be found eligible during that time period. The reasonable opportunity period will be extended beyond 90 days if the individual is making a good faith effort to obtain the documentation.

Verification of SSN will be in accordance with Sections 14105-14105.1.

Individuals will not be required to provide additional information or documentation unless the information cannot be obtained electronically or is not reasonably compatible with the attested information.

Reasonably compatible means that the information provided by an electronic data source is generally consistent with the information reported by the applicant or beneficiary. Income verification obtained through an electronic data source shall be considered reasonably compatible when:

- attestation of income and the electronic verification are at or below the income standard;
- attestation of income and the electronic verification are above the income standard; and

- attestation of income is at or below the income standard and the electronic verification is above the income standard and the difference between the two is 25% or less.

When the difference between the attestation of income and the electronic verification is more than 25%, a reasonable explanation will be sought from the applicant or beneficiary. A reasonable explanation may include, but is not limited to, a loss of employment or reduced hours of employment. If both the reported income and the data source indicate that the income is below the applicable standard then no additional information is needed.

Post-enrollment verification will be completed in accordance with the agency's verification plan approved by the Centers for Medicare & Medicaid Services (CMS). Post-enrollment verification of income and Medicare will be completed within thirty (30) days of the date of enrollment. When additional information is needed to complete the eligibility determination, the agency will request such additional information from the individual. The individual will be provided thirty (30) days to respond to the request for additional information. If the additional information requested is not provided, eligibility will be terminated.

Exceptions to the verification requirements will be permitted on a case-by-case basis when documentation does not exist or is not reasonably available, such as for individuals who are homeless or have experienced domestic violence or a natural disaster. The exception does not apply to the verification requirements for citizenship and immigration status.

17 DE Reg. 503 (11/01/13)
17 DE Reg. 731 (01/01/14)
26 DE Reg. 590 (01/01/23)

14810 RESERVED
13 DE Reg. 1540 (06/01/10)
17 DE Reg. 503 (11/01/13)

14820 Changes in Circumstances

At the time of application and renewal, individuals will be informed that they are responsible for notifying the agency about changes in circumstances that may affect eligibility. Changes may be reported via the ASSIST self-service web site, by telephone, via mail, in person, and through other commonly available electronic means. Eligibility will be redetermined promptly between regularly scheduled renewals when information about a change in circumstance may affect eligibility.

If the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, the agency will redetermine eligibility at the appropriate time based on such changes.

Failure to report changes that may affect eligibility may result in an overpayment being filed or legal action taken to recover funds expended during periods of ineligibility.

17 DE Reg. 503 (11/01/13)

14830 State To State Transfer Of Medicaid Eligibility

Medicaid benefits do not automatically transfer when a Medicaid client moves from one state to another. The Medicaid client must cancel Medicaid in one state and call the new state to establish coverage.

In the case of an individual who has moved to Delaware from another State, the individual is no longer a resident of the first State. The individual is ineligible in that State. However, the case may not be closed yet due to administrative process.

We must not wait for the case to be closed in the old State of residence in order to open the Medicaid case here in Delaware (the new State of residence) provided the individual has been found eligible here. The fact that a case is open in another State is not sufficient reason to deny or delay an eligibility decision if the individual has established Delaware residency and is otherwise eligible.

14840 Confidentiality

Section 1902(a)(7) of the Social Security Act and 42 CFR Subpart F require Medicaid agencies to provide safeguards that restrict the use or disclosure of information about applicants and recipients to purposes directly connected with the administration of the Medicaid Program.

Purposes directly related to administration of the Medicaid Program include establishing eligibility, providing services for recipients, determining the amount of medical assistance, and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program.

At a minimum, the types of information about applicants and recipients that must be safeguarded and not released without consent include:

a. Names and addresses;
b. Medical services provided;
c. Social and economic conditions or circumstances;
d. Agency evaluation of personal information;
e. Medical data, including diagnosis and past history of disease or disability;
f. Information received for verifying income eligibility and amount of medical assistance payments; and
g. Information about third party liability.

See Administrative Notice:

A-14-98 Subpoenas for Public Assistance Records

14840.1Release Of Information To Medicaid Providers

Medicaid providers have a contractual obligation to safeguard information about Medicaid recipients. Providers may have access to certain eligibility information if they can provide:

- a Medicaid identification number (MCI)

  or

- two of the following identifying factors: individual's full name, date of birth, Social Security number;

  AND

the date of service.

Providers who supply the above identifying factors may be given the following information:

a. correct spelling of the recipient's name;
b. MCI number;
c. date of birth;
d. an indication whether the individual is eligible for the date of service given or for a range of dates given. Providers may not be given all periods of eligibility;
e. third party liability information including policy number and type of coverage (for Medicare, only a yes/no indicator for Parts A and B may be provided);
f. prior authorization requirements;
g. restricted coverage.

NOTE: Transportation providers may be given the address and phone number of the recipient because this information is necessary to provide the service.

14840.2 Release Of Information To Interagencies

At the time of application, individuals are informed that all eligibility information is confidential and disclosure without written permission of the individual is limited. Medicaid has the authority to responsibly share information concerning applicants and recipients with:

a. other DHSS employees;
b. other Federal or federally assisted programs that provide assistance to individuals on the basis of need (SSI, HUD);
c. contracted service providers (DCIS and HCBS contractors);
d. consultants (Pre-Admission Screening Annual Resident Review or PASARR, physician consultant);
e. members of multidisciplinary teams providing direct services to the clients (DDDS teams composed of nurse, social worker, and psychologist); and

f. persons officially charged with administrative audit or program evaluation (Independent Professional Review or IPR , Peer Review Organization or PRO).

14840.3 Release Of Information For Legal Requests And An Emergency Situation

Information may be released to comply with a subpoena or other valid court order and in emergency situations when necessary to protect or warn others of imminent threats to their safety. In these circumstances, the case record will be documented with the reason for the disclosure and written notification of the disclosure will be sent to the client's last known address.

14840.4 Release Of Information To Others

Medicaid must obtain specific written permission from the individual before releasing information to other persons or sources.

14850 Medical Assistance Cards

The Medical Assistance Card is the instrument that verifies an individual's eligibility for benefits. The card is renewed each month and is valid only for time period specified on the card. Refer to the Delaware Medical Assistance Provider Manual for more information about Medical Assistance Cards.

14900 Enrollment In Managed Care

On May 17, 1995, Delaware received approval from the Health Care Financing Administration (HCFA) (on June 14, 2001, HCFA was renamed Centers for Medicare and Medicaid Services [CMS]) for a Section 1115 Demonstration Waiver that is known as the *Diamond State Health Plan.* The basic idea behind this initiative is to use managed care principles and a strong quality assurance program to revamp the way health care is delivered to Delaware's most vulnerable populations. The *Diamond State Health Plan* is designed to provide a basic set of health care benefits to current Medicaid beneficiaries as well as uninsured individuals in Delaware who have income at or below 100% of the Federal Poverty Level (FPL). The demonstration waiver will mainstream certain Medicaid recipients into managed care to increase and improve access to medical service while improving cost effectiveness and slowing the rate of growth in health care costs.

Program Expansions

Effective July 1, 2002, a State operated managed care organization, *Diamond State Partners*, was implemented. Individuals may enroll in either the *Diamond State Health Plan* or *Diamond State Partners*

Effective April 1, 2012, the Diamond State Health Plan is expanded to include Long Term Care Medicaid and other full-benefit dual eligibles. This Long Term Care Managed Care Program is called Diamond State Health Plan Plus. Long Term Care Medicaid recipients and other full-benefit dual eligibles must enroll in Diamond State Health Plan Plus.

Managed Care Eligibility

The majority of the Medicaid population receiving Medicaid services will be enrolled into the Diamond State Health Plan, Diamond State Health Plan Plus, or Diamond State Partners. The following individuals cannot enroll in Diamond State Health Plan, Diamond State Health Plan Plus, or Diamond State Partners:

a. Individuals entitled to or eligible for a Medicare Savings Program (QMB, SLMB);
b. Individuals residing in an intermediate care facility for the developmentally disabled (ICF/MR);
c. Individuals covered under the Developmentally Disabled waiver program;
d. Individuals that choose to participate in the Program of All-inclusive Care for the Elderly (PACE);
e. Non lawful and non qualified non citizens (aliens);
f. Individuals eligible under the Breast and Cervical Cancer Treatment Group;
g. Presumptively eligible pregnant women;
h. Individuals in need of only the 30-Day Acute Care Hospital program.

12 DE Reg. 446 (10/01/08)
15 DE Reg. 1717 (06/01/12)

14910 Restricted Recipients

Certain recipients who are exempt from the Diamond State Health Plan are restricted or locked-in when it has been determined that they are engaged in abusive or fraudulent practices such as overutilization of emergency room services or prescription drugs, lending a Medical Assistance card to an unauthorized person, etc. In general, restriction means that fee for service payments are limited to one primary physician and one primary pharmacy. Women are also permitted one obstetrician/gynecologist. Upon referral from the primary physician, any recipient with a special medical condition is permitted to have a specialist as an additional caretaker. If the restricted recipient visits other doctors or has prescriptions filled at other pharmacies, the Delaware Medical Assistance Program will not pay for these unauthorized claims and the recipient can be held responsible for such claims. Refer to the Delaware Medical Assistance Provider Manual for more information about restricted recipients.

14920 Retroactive Coverage

The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual:

Received Medicaid services, at any time during that period, of a type covered under the plan; and

Would have been eligible for Medicaid in one of the below retroactive eligibility groups at the time the individual received the services if the individual had applied (or someone had applied on their behalf) regardless of whether the individual is alive when application for Medicaid is made; and

Is eligible under 1 of the below eligibility groups at the time of application for Medicaid.

Individuals eligible under the Delaware Healthy Children's Program (DHCP) are not eligible for retroactive Medicaid.

Effective April 1, 2012, those that may be found eligible for retroactive Medicaid coverage include:

a. Individuals entitled to or eligible for a Medicare Savings Program (excluding QMB);

b. Individuals residing in a nursing facility;

c. Individuals residing in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or for individuals with mental disease (ICF/IMD);

d. Individuals in need of only the 30-day Acute Care Hospital Program (in no case should the effective date be earlier than the first day of hospitalization);

e. Women eligible under the Breast and Cervical Cancer Treatment Group;

f. Individuals eligible under the Medicaid for Worker’s with Disabilities Group (provided premium requirements are met).

Effective August 1, 2019, those that may be found eligible for retroactive Medicaid coverage include:

a. Pregnant and Postpartum Women.

b. Infants under age 1.

c. Individuals under the age of 19.

Example 1: A woman (over the age of 19) applies for Medicaid March 1, 2020 and requests retroactive Medicaid for the previous three months (February, January and December). She had a baby on December 10, 2020 so she was in her postpartum period through February 2020. She is not eligible for retroactive Medicaid because she does not qualify for and is not receiving Medicaid in any of the retroactive eligibility groups listed above at the time of her application.

Example 2: An individual applies for Medicaid on February 2, 2020 and requests retroactive Medicaid. The individual turned 20 years old on January 31, 2020 and was 19 years old during the three-month retroactive Medicaid period. This individual is not eligible for retroactive Medicaid because at the time of application the individual was not in or eligible for one of the above retroactive Medicaid eligibility groups.

Example 3: A woman applies for Medicaid on March 10, 2020 during her post-partum period. She had her baby on February 5, 2020. As long as she meets all financial and technical eligibility requirements for one of the retroactive Medicaid eligibility groups listed above at the time of application and during the three (3) months immediately preceding the month of application, she is eligible for retroactive Medicaid coverage for December 2019, January 2020, and February 2020.

15 DE Reg. 1717 (06/01/12)
26 DE Reg. 952 (05/01/23)

14920.1 Retroactive Coverage Limitations

Effective August 1, 2019 retroactive Medicaid coverage is available to some individuals who are eligible for enrollment under the Diamond State Health Plan or the Diamond State Health Plan Plus.

See DSSM 14920 for eligibility groups that may be found eligible for retroactive Medicaid coverage.

15 DE Reg. 1716 (06/01/12)
26 DE Reg. 952 (05/01/23)

See 14920.1 Retroactive Coverage Limitations - History

14920.2 Retroactive Coverage Of Medical Bills

Individuals or families who apply for Medicaid and who may be eligible for Diamond State Health Plan or the Diamond State Health Plan Plus may be eligible for retroactive Medicaid coverage of any unpaid medical bills incurred in any of the three months prior to the month in which they applied. However, certain requirements must be met in order for these bills to be paid under Medicaid.

a. The client must have been eligible in all respects for Medicaid in one of the retroactive eligibility categories in the month(s) that the medical services were received (including Delaware residency).

b. The medical bill must be for a service covered by Medicaid.

c. The client did not have any third party coverage that would have been responsible for paying the bill.

d. The medical service must have been given by a provider who was a participant in the Delaware Medicaid program at the time of service. If the provider was not enrolled at the time of the service, the provider may enroll retroactively (up to 12 months).

26 DE Reg. 952 (05/01/23)

14920.3 Retroactive Coverage Time Limits

There is no time limitation on requests for retroactive coverage. They may be processed at any time.

26 DE Reg. 952 (05/01/23)

14920.4 Retroactive Application Process

Requests for retroactive Medicaid are received in various ways as described below:

a. Applicants indicate on the application that they have unpaid medical bills in the three months prior to the month of application.

b. Many requests are received over the telephone from clients who have an unpaid bill.

c. The Medicaid units receive lists from various medical providers such as Division of Public Health, and the school districts requesting assistance with the resolution of an unpaid bill for a Medicaid client.

d. The SSI Medicaid Unit receives data from the Social Security Administration via the SDX regarding individuals who need retroactive coverage.

14920.5 Retroactive Eligibility Determination

If the individual is determined to be eligible for retroactive coverage, the worker must confirm that the date of service of the individual's medical bill(s) falls within the 3 months prior to the month of application and that the individual meets the financial and technical eligibility requirements under Medicaid in 1 of the programs eligible for retroactive coverage. Retroactive coverage for Children’s Community Alternative Disability Program must be approved by the Medical Review Team. Verify income or resources through ASSIST Worker Web (AWW) or other available electronic data sources, if available. If information is not in AWW or available through other electronic data sources, accept the individual's declaration on the application and obtain post-eligibility verification in accordance with DSSM 14800.

Obtain information about third party liability information and forward to the TPL Unit.

A notice of Retroactive Medicaid Approval or Denial will be used to inform the client of the agency's disposition of the request for retroactive coverage. The client should be aware that even those bills submitted for payment may not be reimbursed by Medicaid (i.e., service not covered by Medicaid, non-participating provider, etc.).

15 DE Reg. 202 (08/01/11)
26 DE Reg. 952 (05/01/23)

14920.6 Retroactive Eligibility For Newborns

A baby born to a woman eligible for and receiving Medicaid on the date of the child's birth is deemed to have filed an application. Also, a mother can apply after a child is born and we will determine her eligibility for 3 month retroactive coverage. If the mother is determined retroactively eligible during her pregnancy or post-partum period, the infant is deemed eligible at birth and remains eligible for 1 year.

13 DE Reg. 1540 (06/01/10)
26 DE Reg. 952 (05/01/23)

14930 Medigap Policies

Section 4354 of OBRA 1990 amends Section 1882 of the Social Security Act and imposes statutory limitations on the sale of Medicare supplemental policies (known as Medigap) to Medicare beneficiaries who are also eligible for Medicaid. The provisions apply to policies sold by insurers after 11/5/91 and to individuals who became entitled to Medicaid after that date. It is unlawful for an insurer to sell or issue any health insurance policy (other than an employer group policy) that duplicates Medicare, Medicaid or other health benefits to which the individual is entitled.

14940 Health Insurance Portability And Accountability Act (HIPAA) Certificates

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is intended to guarantee the availability of health insurance coverage for employees and individuals and for limiting the use of preexisting condition restrictions. The law includes portability provisions intended to help ensure health care coverage for employees who move from one job to another. Before this law was passed, changing jobs could result in a temporary loss of comprehensive health coverage during the time it took to meet preexisting condition limitations.

HIPAA requires group health plans and health insurance issuers offering group health insurance coverage to reduce any preexisting condition limitation time period by the length of qualifying prior coverage an individual has for that condition. Qualifying prior coverage includes coverage under a group health plan, an individual health plan, Medicare, or Medicaid. The concept behind qualifying prior coverage is that individuals should be given credit for previous insurance when moving from one group plan to another.

Medicaid must send certificates of coverage to individuals upon request. The certificate must be sent to individuals who request one regardless of the status of the case (open or closed). We must also issue certificates automatically when an individual loses Medicaid coverage. The certificate will show time periods of Medicaid eligibility back to 7/1/96.

14950 Guaranteed Eligibility

All guaranteed eligibility will end effective 9/30/2002. Individuals who lose eligibility effective 4/30/2002 may receive up to five more months of guaranteed eligibility. Individuals who lose eligibility 5/31/2002 or after will not receive a period of guaranteed eligibility

14950.1 Coverage Under the DSHP Benefits Package

The service package and wrap around services are described in the General Policy Section of the Delaware Medical Assistance Program Provider Services Manual.

14960 Cost Sharing

Section 1902(a)(14) of the Social Security Act permits states to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges.

14960.1 Co-Payment Requirement

Effective January 10, 2005, clients have a nominal co-payment for generic and brand name prescription drugs as well as over-the-counter drugs prescribed by a practitioner.

The co-payment is based upon the cost of the drug as follows:

Medicaid Payment for the Drug	Co-payment
$10.00 or less	$.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The co-payment is imposed for each drug that is prescribed and dispensed.

9 DE Reg. 569 (10/01/05)

149601.1 Cumulative Maximum Monthly Co-payment

Effective July 1, 2005, there is a cumulative maximum monthly co-payment amount equal to $15.00 for each recipient. Any prescriptions dispensed after the cumulative maximum monthly co-payment amount is met are not subject to a co-payment.

9 DE Reg. 569 (10/01/05)

14960.2 Exclusions from Co-payment Requirement

The following individuals and services are excluded from the co-payment requirement:

a. individuals under age 21
b. pregnant women, including the postpartum period
c. individuals eligible under the long term care nursing facility group or the acute care hospital group
d. emergency services
e. family planning services and supplies
f. hospice services

14960.3 Inability to Pay

The pharmacy provider may not refuse to dispense the prescription(s) subject to the co-payment requirement because of the individual's inability to pay the co-payment amount. When a recipient indicates that he or she is unable to meet the co-payment requirement, the pharmacy provider must dispense the prescription(s) as written. Medicaid reimbursement for the prescription(s) will be the Medicaid fee minus the applicable co-payment amount.

The recipient remains liable for the co-payment amount and is responsible for paying the pharmacy when financially able. The pharmacy provider is permitted to pursue reimbursement of the co-payment amount from the recipient.

8 DE Reg. 1017 (01/01/05)

14970 Medicare Prescription Drug Program

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to individuals who are entitled to receive Medicare benefits under Part A or Part B, beginning on January 1, 2006. Coverage for the prescription drug

benefit will be provided through private prescription drug plans (PDPs), which will offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA-PDs), which will offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Part C of Medicare.

Effective January 1, 2006, Medicaid beneficiaries who are entitled to receive Medicare benefits under Part A or Part B will no longer receive their pharmacy benefits under the Medicaid Program, except for drugs that are excluded from Part D. Any prescribed drug covered by Medicaid remains subject to the Medicaid co-payment requirement.

9 DE Reg. 774 (11/01/05)