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

15000 Family and Community Medicaid Eligibility Groups

15100 Parent/Caretaker Relative Group

This section describes the eligibility requirements for the Parent/Caretaker Relative Group in accordance with Section 1931 of the Social Security Act.

15100.1 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:

"**Caretaker relative**" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

(1) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(2) The spouse of such parent or relative, including same sex marriage or civil union, even after the marriage or civil union is terminated by death or divorce.

(3) Another relative of the child based on blood (including those of half-blood), adoption, or marriage; the domestic partner of the parent or caretaker relative; or an adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

"**Dependent Child**" means a child who is under age 18 or is age 18 and a full-time student in a secondary school (or equivalent vocational or technical training), and if before attaining age 19, the child may reasonably be expected to compete such school or training.

15100.2 Parent/Caretaker Relative General Eligibility Requirements

An individual must meet the general eligibility requirements described in Section 14000.

15100.3 Technical Eligibility

A parent or caretaker relative may be eligible under this group when the parent or caretaker relative assumes primary responsibility for the care and control of a dependent child living in their household even if the child or parent or caretaker relative is temporarily absent.

15100.4 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000.

Household income must not exceed 87% of the Federal Poverty Level (FPL).

15110 Transitional Group

This section describes the eligibility requirements for the Transitional Group in accordance with Section 1925 of the Social Security Act. Transitional Group eligibility is an extended eligibility period of up to twelve months for a family who becomes ineligible due to an increase in earned income or hours of employment. Transitional Group eligibility is divided into two periods of six months each.

The twelve-month extension period shall be rescinded when federal authorization or the allocation of federal funding is discontinued and shall include an extension period of four consecutive months described in Section 15110.10.

15110.1 Transitional Group General Eligibility Requirements

An individual must meet the general eligibility requirements described in Section 14000.

15110.2 Three out of Six Months Requirement

An individual must have received Medicaid under Section 15100 Parent/Caretaker Relative Group in three of the six months immediately preceding the month of ineligibility under such section.

A parent or caretaker relative is considered to have received Medicaid in any month Medicaid was correctly provided. This does not include Medicaid provided:

- in error;
- pending a hearing if the agency's action is upheld and the Medicaid provided is recoverable as an overpayment; or
- for a month of ineligibility because of administrative notice requirements.

Medicaid must have been received in Delaware for three out of the six months.

15110.3 Increase in Earned Income or Hours of Employment

The family must become ineligible for Medicaid because of an increase in earned income or hours of employment of the parent or caretaker relative.

This happens when:

- an increase in earned income makes the family ineligible; or
- an increase in other income when combined with an increase in earned income causes ineligibility. The parent or caretaker relative whose earnings cause ineligibility must meet the three out of six months requirement in Section 15110.2.

The increase in earned income or hours of employment must have a causative effect on the loss of eligibility. The following steps are used to determine if an increase in earned income (or other factor) had a causative effect.

1. Determine if the increase in earned income or hours of employment would have resulted in the loss of eligibility if all other factors in the case remained the same (there was no other change in income, no change in family composition, etc.).

   If yes, the family is eligible for the Transitional Group.

   If no, go to step 2.

2. Determine if events other than the increase in earned income or hours of employment would have resulted in the loss of eligibility if the earned income or hours of employment had stayed the same.

   If yes, the family is not eligible for the Transitional Group.

   If no, go to step 3.

3. Determine if the family is ineligible when all changes are considered.

   If yes, the family is eligible for the Transitional Group. The increase in earned income or hours of employment was essential to the loss of eligibility. Without that increase, the family would not have lost eligibility.

   If no, eligibility continues under the Parent/Caretaker Relative Group.

15110.4 Child Living in the Home

The parent or caretaker relative must continue to have a dependent child, as defined in Section 15100.1 living in the home.

When the only child no longer meets the age requirement, the parent or caretaker relative is no longer eligible for the Transitional Group. When one child turns age 18 or 19, but there is another child in the family, the child who turns age 18 or 19 is no longer considered a member of the Transitional Group family unit. The rest of the family remains eligible for the Transitional Group.

15110.5 Composition of a Transitional Group Family Unit

Transitional Group coverage is provided to all individuals who were included in the family at the time the family became ineligible. This includes a dependent child under the Children Group described in Section 15300. A recipient of SSI is not included in the family unit. Family members who enter the household or family members who were absent but return may be found eligible. An individual who enters the family unit (including a child born to the family during the transitional period) may be eligible for Transitional Group coverage if that individual would have been included in the parent or caretaker relative's family unit if the household were applying in the current month.

The earned income of an individual who has entered or returned to the family unit is included in the gross earnings test and that individual is counted when determining the family size. The earned income of a dependent child, regardless of student status, is not counted.

15110.6 First Month of Transitional Group Eligibility

Transitional Group eligibility begins with the month of ineligibility under the Parent/Caretaker Relative Group due to an increase in earned income or hours of employment. A family who is not timely in reporting the start of employment or an increase in earned income or hours of employment could have the extension period reduced. The family must be notified they are eligible for the Transitional Group and the reasons why coverage under the Transitional Group could be terminated.

15110.7 Transitional Group Eligibility during First Six-Month Period

The family will receive Transitional Group coverage without any reapplication for the first six months. To continue to receive Transitional Group coverage throughout the first six-month period there must be a dependent child living in the home. Eligibility will be terminated if the family is found to have received Medicaid fraudulently in the preceding six months. A conviction for fraud must be made by a court of competent jurisdiction.

15110.8 Transitional Group Eligibility during Second Six-Month Period

To continue to receive Medicaid during the second six-month period, the following eligibility conditions described in Section 15110.8.1, Section 15110.8.2, and Section 15110.8.3 must be met.

15110.8.1 Child Living in the Home

There must be a dependent child living in the home.

15110.8.2 Employment of Caretaker Relative

The parent or caretaker relative must be employed during each month unless good cause exists.

Good cause includes the following:

a. Circumstances beyond the individual's control such as but not limited to illness, illness of another family member requiring the wage earner's presence, a household emergency, the unavailability of transportation, and the lack of adequate dependent care.

b. Circumstances in which employment was unsuitable such as wages offered less than the Federal minimum wage; employment on a piece-rate basis and the average hourly yield the employee receives is less than the Federal minimum wage; unreasonable degree of risk to one's health and safety; the individual is physically or mentally unfit to perform the employment as documented by medical evidence or reliable information from other sources; the distance from the individual's house to place of employment is unreasonable considering the expected wage and the time and cost of commuting; or the working hours or nature of employment interferes with the members religious observance, convictions or beliefs.

c. Discrimination by an employer based on age, race, sexual orientation or gender identity, disability, religious belief, national origin, or political belief.

d. Work demands or conditions that are unreasonable such as working without being paid on schedule.

e. Acceptance of other employment or enrollment at least half-time in a school, training program, or college.

f. Resignations by persons under the age of 60 that are recognized by the employer as retirement.

g. Leaving a job in connection with patterns of employment in which workers move from one employer to another as in migrant farm labor or in construction work.

15110.8.3 Limit on Gross Monthly Earned Income

The family's gross monthly earned income minus the monthly costs of necessary dependent care must not exceed 185% of the federal poverty level (FPL). The FPL is effective each July for the Transitional Group. There are no limits on necessary dependent care costs. All unearned income and the earned income of a dependent child is excluded.

15110.9 Twelve-Month Period of Transitional Group Eligibility

A family may receive twelve months of Transitional Group coverage even if eligibility is re-established under the Parent/Caretaker Relative Group. The clock on the twelve-month period does not stop running when eligibility for Medicaid under this group is re-established. The twelve months of Transitional Group eligibility run concurrently with months of eligibility under the Parent/Caretaker Relative Group.

If eligibility is lost under the Parent/Caretaker Relative Group for non-work reasons, the Transitional Group extension period is unaffected. If eligibility is lost again under the Parent/Caretaker Group for earned income, a new Transitional Group period may begin.

15110.10 Four-Month Period of Transitional Group Eligibility

This section applies if the twelve-month extension period described above is not re-authorized. A family may receive up to four months of Transitional Group coverage provided the requirements described in Section 15110.2, Section 15110.3, and Section 15110.4 are met. There is no income test throughout the four-month period.

15120 Prospective Group

This section describes the eligibility requirements under the Prospective Group. Prospective Group is an extended eligibility period of up to four consecutive calendar months for a family who becomes ineligible due to an increased collection of spousal support.

15120.1 Prospective Group General Eligibility Requirements

An individual must meet the general eligibility requirements described in Section 14000.

15120.2 Three out of Six Months Requirement

An individual must have received Delaware Medicaid under the Parent/Caretaker Relative group in three of the six month immediately preceding the month of ineligibility under that section.

A parent or caretaker relative is considered to have received Medicaid in any month Medicaid was correctly provided. This does not include Medicaid provided:

- in error;
- pending a hearing if the agency's action is upheld and the Medicaid provided is recoverable as an overpayment; or
- for a month of ineligibility because of administrative notice requirements.

15120.3 Collection of Spousal Support

The parent or caretaker relative must have lost eligibility wholly or partly as a result of new or increased spousal support collections. The collection of spousal support must cause or actively contribute to ineligibility. Regulations require that the collection of spousal support be paid directly to the IV-D agency – the Delaware Division of Child Support Enforcement.

15120.4 Child Living in the Home

The parent or caretaker relative must continue to have a dependent child as defined in Section 15100.1 living in the home.

When the only child no longer meets the age requirement, the parent or caretaker relative is no longer eligible for Prospective Group coverage. When one child turns age 18 or 19, but there is another child in the family, the child who turns age 18 or 19 is no longer considered a member of the Prospective Group family unit. The rest of the family remains eligible for Prospective Group coverage.

15120.5 First Month of Prospective Group Eligibility

Prospective Group eligibility begins with the month of ineligibility under the Parent/Caretaker Relative Group due to new or increased spousal support collections. A family who is not timely in reporting the start of new or increased spousal support collections could have the extension period reduced. The family must be notified they are eligible for the Prospective Group and the reasons why Prospective Group coverage could be terminated.

15120.6 Composition of Prospective Group Family Unit

Prospective is provided to all individuals who were included in the family at the time the family became ineligible. This includes a dependent child in the Children Group defined in Section 15300. In addition, family members who enter the household or family members who were absent but return may be found eligible. An individual who enters the family unit (including a child born to the family during the extended period) may be eligible for Prospective Group coverage if that individual would have been included in the parent or caretaker relative's family unit if the household were applying in the current month.

15200 Pregnant Woman Group

The section describes the eligibility requirements for the Pregnant Woman Group.

15200.1 Definitions

Statutory Authority
42 CFR 435.116
42 CFR 435.170

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

"**Pregnant Woman**" means a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 12 months, and then ends on the last day of the month in which the 12 month period ends.

See 15200.1 Definitions - History

26 DE Reg. 323 (10/01/22)

15200.2 Pregnant Woman Group General Eligibility Requirements

A pregnant woman must meet the general eligibility requirements described in Section 14000. Exception: A pregnant woman is not required to cooperate in establishing paternity and obtaining medical support.

15200.3 Technical Eligibility

A woman may apply for Medicaid at any time during her pregnancy or 60 day postpartum period, as defined under 15200.6 Postpartum Period.

Self-attestation of pregnancy and the unborn fetus count is accepted unless the information provided is not reasonably compatible with other available information. Other available information may include medical claims that are not reasonably compatible with such attestation.

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

15200.4 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000. The pregnant woman counts as at least two family members for the financial eligibility determination. If a pregnant woman is diagnosed with a multiple pregnancy, the unborn fetus count is increased accordingly.

Household income must not exceed 212% of the Federal Poverty Level (FPL).

17 DE Reg. 845 (02/01/14)

15200.5 Continuous Eligibility

Once a pregnant woman is determined eligible, she remains eligible throughout the pregnancy and the postpartum period regardless of changes in household income.

15200.6 Postpartum Period

Statutory Authority
42 CFR 435.116
42 CFR 435.170

The 60-day postpartum period is a mandatory extension of coverage for women who were determined eligible under the pregnancy eligibility category. A woman applying in her postpartum period could be determined eligible using the eligibility criteria applicable to postpartum coverage (pregnant woman group), even if she was not open in the pregnant woman group at the time of the birth of her child.

The 12 month postpartum period is a mandatory extension of coverage for women who were determined eligible in the month the pregnancy ends, in a month prior to the month the pregnancy ends (while still pregnant), or who received services while pregnant during a period of retroactive eligibility. A woman cannot apply and be found eligible for the postpartum period alone. Coverage begins on the day the pregnancy ends and continues through the last day of the month in which the 12 months ends.

Undocumented aliens are not eligible for the postpartum period.

26 DE Reg. 323 (10/01/22)

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

15210 Deemed Newborn Group

The section describes the eligibility requirements for the Deemed Newborn Group.

An infant born to a woman eligible for and receiving Delaware Medicaid (including emergency services and labor and delivery only coverage) on the date of the infant's birth is deemed eligible at birth.

15210.1 Deemed Newborn Group General Eligibility Requirements

An infant must meet the general eligibility requirements described in Section 14000.

Exceptions: An application for the newborn is not required. A newborn deemed eligible does not have to provide or apply for a Social Security number until age one.

15210.2 Financial Eligibility

There is no income test. Eligibility begins on the date of birth and continues until the end of the month in which the

infant turns age one regardless of changes in income. The newborn's eligibility is not dependent on the continuation of the mother's eligibility for Medicaid.

15300 Children Group

This section describes the eligibility requirements for the Children Group.

15300.1 Children Group General Eligibility Requirements

A child must meet the general eligibility requirements described in Section 14000.

15300.2 Technical Eligibility

A child must be under age 19.

15300.3 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies described in Section 16000.

Household income for children under age 1 must not exceed 212% of the Federal Poverty Level (FPL).

Household income for children age 1 through age 5 must not exceed 142% of the Federal Poverty Level (FPL).

Household income for children age 6 through age 18 must not exceed 133% of the Federal Poverty Level (FPL).

17 DE Reg. 845 (02/01/14)

15300.4 Mandatory Continuation of Eligibility for Children

A child receiving inpatient services in a hospital or long-term care facility at the end of the month in which the child turns age 19 remains eligible until the end of the inpatient stay. The child must continue to meet the general and financial eligibility requirements described in Section 15300.1 and Section 15300.3.

15400 Adult Group

This section describes the eligibility requirements for the Adult Group.

15400.1 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:

"**Minimum essential coverage**" means coverage defined in section 5000A(f) of subtitle D of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act, and implementing regulations of such section issued by the Secretary of the Treasury. Minimum essential coverage includes any of the following:

- Medicare Part A;
- Medicaid;
- Children's Health Insurance Program (CHIP);
- Medical coverage under chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;
- a health care program under chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury;
- a health plan under section 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers);
- The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 United States Code 1587 note).

15400.2 Adult Group General Eligibility Requirements

An adult must meet the general eligibility requirements described in Section 14000.

15400.3 Technical Eligibility

An adult must:

a) be age 19 or older and under age 65;
b) not be pregnant;
c) not be entitled to or enrolled in Medicare Part A or B;
d) not be eligible under the following mandatory groups – Supplement Security Income (SSI) and related groups,

Parent/Caretaker Relative, Transitional, Prospective, Pregnant Woman, Deemed Newborn, Children, Former Foster Child, or Title IV-E Foster Children.

A parent or caretaker relative living with a dependent child as defined in Section 15100.1 shall not be eligible in the Adult Group unless the child is enrolled in minimum essential coverage.

15400.4 Financial Eligibility

Financial eligibility is determined using the modified adjusted gross income (MAGI) methodologies in Section 16000.

Household income must not exceed 133% of the Federal Poverty Level (FPL).

15500 Title IV-E Foster Children Group

This section describes the eligibility requirements for Title IV-E Foster Children Group.

15500.1 Title IV-E Foster Children Group General Eligibility Requirements

The child must meet the general eligibility requirements in Section 14000. Exception: The state of residence is the state where the child lives even if the foster care payment originates from another state.

15500.2 Technical Eligibility

Age: The child must be under age 21.

Payment by a Public Agency: The child must receive foster care maintenance payments under Title IV-E of the Social Security Act.

15500.3 Eligibility Determination

The Delaware Department of Services for Children, Youth, and their Families (DSCYF) is responsible for the eligibility determination.

15510 Foster Children Group

(Repealed)

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

15510.1 Foster Children Group General Eligibility Requirements

(Repealed)

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

15510.2 Technical Eligibility

(Repealed)

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

15510.3 Financial Eligibility

(Repealed)

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

15510.4 Effective Date of Coverage

(Repealed)

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

15520 Adoption Assistance Group

This section describes the eligibility requirements for the Adoption Assistance Group.

15520.1 Adoption Assistance Group General Eligibility Requirements

The child must meet the general eligibility requirements described in Section 14000. The state of residence is the state where the child lives even if the adoption agreement originates from another state.

15520.2 Technical Eligibility Requirements

Age: The child must be under age 21.

Adoption Assistance: There must be an adoption assistance agreement in effect under Title IV-E of the Social Security Act, whether or not an adoption assistance payment is being made or an interlocutory (the final order of adoption) or other judicial decree of adoption has been issued.

15520.3 Eligibility Determination

Delaware Department of Services for Children, Youth, and Their Families (DSCYF) is responsible for the eligibility determination.

15530 Adoption Subsidy Group

This section describes the eligibility requirements for the Adoption Subsidy Group.

15530.1 Adoption Subsidy Group General Eligibility Requirements

The child must meet the general eligibility requirements described in Section 14000.

15530.2 Technical Eligibility

Age: The child must be under age 21.

Adoption Agreement: There must be an adoption assistance agreement (other than an agreement under Title IV-E of the Social Security Act) in effect for a child with special needs for medical or rehabilitative care. Children moving into Delaware from another state must have a signed adoption assistance agreement with the former state. The child must have been Medicaid eligible prior to the adoption assistance agreement.

Subsidy: The child must receive a medical/psychological subsidy from Delaware Department of Services for Children, Youth, and Their Families (DSCYF).

15530.3 Financial Eligibility

There is no income or resource test.

15540 Infants Awaiting Adoption Group

(Repealed)

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

15540.1 Infants Awaiting Adoption Group General Eligibility Requirements

(Repealed)

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

15540.2 Technical Eligibility

(Repealed)

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

15540.3 Financial Eligibility

(Repealed)

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

15540.4 Effective Date of Coverage

(Repealed)

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

15540.5 Termination of Eligibility

(Repealed)

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

15550 Former Foster Children Group

This section describes the eligibility requirements for the Former Foster Children Group. This group is established through the enactment of the Affordable Care Act of 2010. Coverage under this group is effective January 1, 2014.

15550.1 Former Foster Children Group General Eligibility Requirements

An individual must meet the general eligibility requirements in Section 14000.

15550.2 Technical Eligibility

An individual must:

15550.2.1 be age 18 or older and under age 26; and

15550.2.2 have been in foster care under the responsibility of the Delaware Department of Services for Children, Youth, and Their Families (DSCYF) and enrolled in Delaware Medicaid upon attaining age 18 or older (up to age 21); or

15550.2.3 Have been in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system; and

15550.2.4 not be eligible under the following mandatory groups – Parent/Caretaker Relative, Transitional, Prospective, Pregnant Women, Children, and Supplemental Security Income (SSI).

20 DE Reg. 908 (05/01/17)

15550.3 Financial Eligibility

There is no income or resource test for this group.

15600 Breast and Cervical Cancer Group

This section describes the eligibility requirements for the Breast and Cervical Cancer Group. This group includes uninsured women who are identified through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need for treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer.

15600.1 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:

"**Comprehensive health insurance**" means a benefit package comparable in scope to the "basic" benefit package required by the State of Delaware's Small Employer Health Insurance Act at Title 18, Chapter 72 of the Delaware Code. To be considered comprehensive health insurance, the benefits package must cover hospital and physician services, laboratory and radiology, and must include coverage for the treatment of breast and cervical cancer.

Comprehensive health insurance does not include time periods when there is no coverage for the treatment of breast or cervical cancer. Examples include when coverage is effective only after a waiting period of uninsurance or after the lifetime limits are exhausted.

Comprehensive health insurance does include insurance that has limits on benefits (such as limits on the number of outpatient visits per year) or high deductibles.

15600.2 Breast and Cervical Cancer Group General Eligibility Requirements

A woman must meet the general eligibility requirements described in Section 14000.

15600.3 Technical Eligibility

Age: The woman must be under age 65. If a woman turns age 65 during her period of coverage, her eligibility terminates. Exception: If the woman is an inpatient in a hospital when she turns 65, eligibility continues until discharge.

Uninsured:

The woman must be uninsured. The woman is not eligible if she has:

a) Medicaid or may be found eligible under any of the following Medicaid mandatory groups - Parent/Caretaker Relative, Transitional, Prospective, Pregnant Woman, Children, Title IV-E Foster Care, Title IV-E Adoption Assistance, or Supplemental Security Income (SSI);

b) Medicare;

c) Comprehensive health insurance;

d) Military Health Insurance for Active Duty, Retired Military, and their dependents.

Screening:

The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to need treatment for either breast or cervical cancer (including a pre-cancerous condition).

A woman is considered to have met the screening requirement if she comes under any of the following categories:

1. CDC Title XV funds paid for all or part of the costs of her screening services.

2. The woman is screened under a state Breast and Cervical Cancer Early Detection Program which her particular clinical service has not be paid for by CDC Title XV funds, but the service was rendered by a provider and/or an entity funded at least in part by CDC Title XV funds; the service was within the scope of the grant, sub-grant or contract under that State program; and the State CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

Treatment:

The woman must need treatment for breast or cervical cancer. The woman meets this requirement when it is the opinion of the woman's treating health professional that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services. These services included diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as treatment itself.

Based on the physician's plan-of-care, a woman who is determined to require only routine monitoring services for a pre-cancerous breast or cervical condition (such as breast examination and mammograms), is not considered to need treatment.

15600.4 Financial Eligibility

There is no income or resource test.

15600.5 Presumptive Eligibility

Presumptive eligibility is a temporary eligibility determination that will provide expedited Medicaid coverage to women in this group during the application processing period. This special application processing procedure will facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. An applicant can be determined presumptively eligible when the agency receives verification that she has been screened for breast or cervical cancer under CDC and needs treatment.

If the information on the application indicates that she may be eligible under one of the mandatory eligibility groups, the agency will first make a determination of presumptive eligibility under this group. Verifications of factors of eligibility for the mandatory group are postponed. Postponed verifications must be provided within 30 days from the date of receipt of the application. The verifications that were postponed are required to determine final eligibility for Medicaid. Presumptive eligibility continues until a final eligibility determination is completed. If the required verifications are not provided, eligibility is terminated.

If the information on the application indicates that the woman is not eligible under one of the mandatory groups, the agency will make a final determination of eligibility under this group provided all verification requirements are met.

15600.6 Eligibility Period

Eligibility may begin up to three months prior to the month of application provided the woman meets all eligibility requirements during those prior three months including having been screened and found to need treatment for breast or cervical cancer.

A woman is not limited to one period of eligibility. A new period of eligibility and coverage can begin each time a woman is screened under the CDC program, has been found to need treatment for breast or cervical cancer, and meets the other eligibility requirements.

15600.7 Benefits

A woman eligible under this group is entitled to full Medicaid coverage. Coverage is not limited to the treatment of breast and cervical cancer.

15600.8 Termination of Eligibility

Eligibility under this group terminates when the woman:

a) attains age 65;
b) acquires comprehensive health insurance;
c) is no longer receiving treatment for breast or cervical cancer
d) no longer meets the general eligibility requirements in Section 14000.

15700 Family Planning Group

(Repealed)

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

15700.1 Family Planning Group General Eligibility Requirements

(Repealed)

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

15700.2 Technical Eligibility

(Repealed)

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

15700.3 Financial Eligibility

(Repealed)

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

15700.4 Benefits

(Repealed)

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

15700.5 Termination of Eligibility

(Repealed)

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

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